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Caring Connections: A Practical Way to Both Show and Teach Caring In Nursing

A thesis by

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ABSTRACT

Hospital care is changing, - dominated by the dollar and technology and the patient is taking second place. Nursing, traditionally known as being a caring profession, is not exempt from the changes and the traditional entrance interview to find caring students has been replaced by a computerised system. Graduates from university programs are being branded as non-caring. This research sought to find practical ways in which nurses showed caring to patients, and to develop a framework which could be used to teach and cultivate caring attributes in undergraduate students.

A broad sweep of the past was taken to show how, dominated by disease and the necessity to take care of the suffering and infirm, nursing has been inextricably linked to the inability of science to cure. The discussion on the impact of the Therapeutic Revolution and a health care system, dominated by the dollar, places nursing and caring in perspective. Some philosophical, religious and psychological notions of caring were briefly explored.

A participative paradigm underpins this research which uses a collaborative inquiry cyclical and reflective process of three phases. In Phase I a group of Graduate Registered Nurses reflected on the enacted/strategies/skills that were used to show caring to patients. Six key enactments were elicited from the total of 64 reflections that were submitted. Phase II constructed a framework that could be used to teach caring, which was then critiqued by an expert group of educators.

Phase III returned to Phases I and II and used a process of reflection-on-reflection and a new emergent meaning of caring in nursing ensued. As a result of this reflection-on-reflection, a reconfiguration of the framework resulted in the development of the *Care* Connections model.

CERTIFICATION OF THESIS

I certify that the ideas, work, results, analyses, interpretations and conclusions reported in this thesis are entirely my own effort, except where otherwise acknowledged. I also certify that the work is original and has not been previously submitted for any other award, except where otherwise acknowledged.

Signature of Candidate

Date

ENDORSEMENT

14.03.06

Signature of Supervisors

20 June 2006

Date

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my **Beloved** …
who finally said "go for it" and never once doubted I would get there.

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PROLOGUE

SOME DAY,
AFTER WE HAVE MASTERED
THE WIND, THE WAVES,
THE TIDES AND GRAVITY
WE SHALL HARNESS THE ENERGIES
OF LOVE.
THEN, FOR THE SECOND TIME
IN THE HISTORY OF THE WORLD,
MAN WILL HAVE DISCOVERED
FIRE.

Peirre Teilhard de Chardin

(1881-1955)

(Exley, 1999, n.p.)

I cannot harness the energies of love, but I have experienced the energies of love.
These energies of love cannot be described or quantified in a formula.
However, I *know* that the energies of love exist.
I also know that caring in nursing exists.

This research is about a special kind of love – in nursing.
When a nurse has nursed for more than 40 years, neither 'the nurse' nor the 'me' can be excluded from the research.
Who is this me?
Student, lecturer, wife (and mate), mother and grandmother, secure in being LOVED
…and a nurse committed to teaching caring in nursing.

This prologue explores briefly the *relationship* between the researcher and the research, while the ongoing *dynamics* of the research and the researcher are dealt with in reflections in text. Olesen (2000), in dealing with the emerging complexities of qualitative research, declares that the involvement of the researcher can be problematic. Among the complexities listed is the problem related to the relationship of the researcher to the research. Olesen (2000, p. 230) notes that the researcher should,

- go beyond "mere reflection on the conduct of the research" – which in essence means that the researcher maintains a,
- …"steady, uncomfortable assessment of the interpersonal and interstitial knowledge-producing dynamics" of the research.

I note that she is also writing about the accumulation of knowledge and the impact that it has on the researcher and the research itself. (Olesen, 2000)

The relationship between the researcher and those with whom the research is being done is also important. Elizabeth Kasl, in the Foreword to *Collaborative Inquiry in Practice*, (Bray, Lee, Smith, & Yorks, 2000) stresses the importance of the researcher being able to participate in order to fully understand the true nature of the research. This she asserts occurs in the participatory paradigm and that once the researchers embark on their first inquiry they will be 'embarking on a learning adventure with potential for being among your most energizing and significant learning experiences.' (p.viii). Quotes from students' dissertations on Collaborative Inquiry are then given. The following is one of a collage of quotations used by Kasl (Bray et al, 2000, p.ix) in the Foreword. It captured my attention and epitomizes for me some of my hopes and aspirations for this research and for the participant Graduate Registered Nurses.

> I dreamed a wonderful dream that filled me full of peace …The dream was about CI (collaborative inquiry) … I was running toward a very deep canyon and I could not see the valley floor ... then like magic a clear, large balloon appeared. It drifted into my hands and I knew that I could toss it to my CI buddies on the other side. When I did so, it came back iridescent and more brilliant… (Smith, 1995, p. 260)

My relationship to the research

I trained at the Johannesburg General Hospital in the late 1950s. In total I spent 15 weeks at the historic Windybrow mansion, the nursing college. We learned basic anatomy and physiology, basic nursing skills and then medical-surgical nursing, special nursing and the 'finals' block of revision. The system was similar to the hospital training in Australia at that time.

However … I loved nursing.

I later taught nurses in the same college where I had started nursing. I supervised, as I myself had been supervised, in the sacred ritual first hour of 'House-Keeping'. Students (armed with their own house-keeping box) dusted the already gleaming ornately carved staircases (wood imported from Australia) and the pristinely kept 'wards'. I later taught at Baragwanath Hospital just outside Soweto, then the largest hospital in the Southern Hemisphere. I also taught at a small mission hospital before coming to Australia to participate in the transfer of nurse education to the tertiary sector.

For some years, every Thursday, I was on an interview panel at the hospital affiliated with our College of Advanced Education (CAE). Prospective students were interviewed and tested for numeracy and aptitude for nursing. My colleague and I had long discussions on caring in nursing. Almost every student we interviewed said that the reason they wanted to nurse was because they cared for people or they wanted to care. What a golden opportunity I missed to collect data. We eventually decided that (when we had time) we would do a study on caring.

At this time a fundamentals of nursing text was published that almost for the first time included a chapter on caring. A colleague says she still recalls me coming to her office in excitement and discussing this new text and challenging her to use it in the following year. It was as if a flame had been lit in my consciousness. This was why I had entered the profession. Then there followed the increasing research on caring and I started a journey on the exploration of caring myself. The years rolled by and my interest in caring in nursing did not wane.

I have wanted to do a PhD for years now. As the family grew, our emphasis was centred on them. Gil (my beloved husband, partner, mate and mainstay) has always said

that I could embark on a PhD as soon as I was a widow. Then he took early retirement and with David (our eldest son) began farming. I became the off-farm income. The Angus cattle took up increasing amounts of Gil's time and he eventually said, "Go for it". Perhaps in the waiting and wanting to do a PhD for so long there has been a period of learning in which I have been preparing subconsciously for this time of formal learning. In addition I think that the wait was Providential. Participatory research would not have been available to me ten or twenty years ago and I think that I might have been frustrated beyond measure with some of the methods that were available at that time.

The 'very deep canyon' of a research project (Smith above) is a useful one. It depicts the research process as being something that demands exploration. The researcher in a participative relationship with 'CI buddies' finds solutions that are 'iridescent'. I would be relying on these 'CI buddies' as we explored the canyon together. I too will be participating in a small way as they journey into their new profession. I feel as if I am approaching the canyon with trepidation. What will I find? It was for me uncharted territory. What are my intuitions, hopes, and expectations of what we are about to explore?

Chapter 1: Introduction

Introduction

There are two constants in the rapidly changing health care scene of the Twenty-first Century; the patient and the need for the essence of nursing – caring. The patients, perhaps more knowledgeable, remain anxious, and their need for caring, however they interpret it, is still as strong as ever.

The nurse, as represented in numerous ways across the centuries, remains a crucial lynchpin in the hospitalised patients' contained world of illness and disease, but the omniscient nurse has changed. University educated and multi-skilled, committed to being a patient advocate, teacher, counsellor, and encourager, the Registered Nurse (RN) of the Twenty-first Century is significantly different from the counterpart of yesteryear. While the caring essence of nursing remains, this quintessence of nursing needs to harmonise with the demands that the scientific advances place on the nursing care of patients. How this caring is enacted is the focus of this research.

In order to achieve clarity and ease of reading the following decisions were made regarding the use of the word care in this thesis. Three different forms of caring are differentiated by using the following format in-text.

- 'caring in nursing' in whatever grammatical context is *Care*
- The philosophical caring as compassion/love/empathy/concern has a capital 'C' as in Caring
- The nursing care that patients have as part of their hospital stay will always be in lower case as in 'care'.

THUS…to ensure clarity, sentences would read as follows:

The literature on *Care* is voluminous and much of it is linked to nursing care in speciality areas such as palliative care. On the other hand the *Care* literature does not always pay attention to the Caring literature of the philosophers such as Lewis and psychologists such as Rogers.

Definitions

Defining the principle concepts in any study is important and this research is no exception. What is different is that although the two principal concepts, nursing

and caring in nursing, are universally understood there are numerous 'universal' definitions. There is therefore an imperative to clarify these two concepts as they will be used in this research. An Australian definition of nursing was selected as it reflected the philosophy of nursing for the researcher and the profession. *Care*, and the choice of its definition, was more complex. Definitions and the reasons for the choices are discussed here.

Nursing

The Australasian Nurse Registering Authorities Conference (ANRAC) competency document begins with a philosophy written as a series of defining statements about nursing. These defining statements are for the most part unambiguous, and an excellent interpretation of nursing. Although they are not repeated in any of the subsequent documents of ANRAC, now the Australian Nursing Council Incorporated (ANCI), it is this defining statement on nursing that has been adopted for this research.

> Nursing is an art and a science. The essence of nursing lies in a unique interplay of knowledge, intuitive and logical thought and a compassion for others.
>
> (ANRAC Competency Project, 1990., p. 4)

Taylor (1991), in her book, *Ordinariness in Nursing*, has an uncomplicated but profound definition of nursing. She is an Australian and committed to holistic care and caring in nursing. She posits that nursing and caring should be redefined and states simply that

> Nursing is what happens between nurses and patients in contexts of care, and it is facilitated by the humanity of both parties as they negotiate the illness experience together
>
> (p. 241).

Note: RN is used to denote the Registered Nurse and is used for both singular and the plural. In the same way GRN is used for the Graduate Registered Nurse/Nurses.

Care

Definitions of *Care* abound. Paley is correct in his analysis of caring in nursing. He concludes that nursings' theoretical obsession with defining *Care* is 'an elusive concept, which is destined to remain elusive - permanently and irretrievably' (Paley, 2001, p. 196).

Benner and Wrubel (1989) give a simple definition in the *Primacy of Caring*, "persons, events, projects, and things matter to people" (p. 1). In contrast Eriksson (1994) defines caring as "caritative love" and nurses' reason for their work being "on the basis of an inner motive of love" (p. 6) These definitions can be depicted as being at opposite poles of meaning or import. Benner and Wrubels' are too simplistic and Eriksson's too philosophical. My garden 'matters' to me and I care for and care about it, but do not have any compassion for it. Nor is my garden looked after from an 'inner motive of love'; that I reserve for my significant others.

Watson gives a number of definitions of caring but prefers to refer to her work as an emerging theory of caring in nursing with an imbedded philosophy of "Clinical Caritas and Caritas Processes". (Watson, 2000a) These concepts will be explored as part of the literature review and have had considerable influence in this research. Watson is careful to note that nursing is about 'transcendental' relationships that nurse and patient develop, and thus, the patient knows that there is caring. Watson explains that caring is not only physical but also embraces "the mind-body-spirit as it reclaims the embodied spirit as the focus of its attention…both art and aesthetics, of *being* as well as *knowing* and *doing*." (Watson, 1999, p. 10) (Watson's italics). The elements of being (compassion and intuition) and knowing (knowledge and logical thought) are in some measure reflected in the ANRAC definition of nursing, above.

Defining caring in nursing for this research needed to be simple and yet reflect the complexity of the practical caring in the busyness of a hospital. It had to be an interpretation that would resonate genuinely with nurses. The definition would also need to reflect my own philosophy of caring in nursing. Thus my definition at the beginning of this research is that,

Care is compassion and is intimately linked with the nuances of tender, loving care.

This statement seemed to be bald and lacking substance, but the phrase 'tender, loving care' usually simply as 'tlc' is an interpretation of caring in nursing

with which all nurses are familiar. While the connotations vary, nurses recognise the phrase and use it in their daily practice. 'Tender, loving care' is applied in countless different ways, always in accord with the unique needs of the patient (or colleague) at any given time. The philosophical concepts are of *being* and the importances of the relational aspects of nursing, which Watson expounds, are foundational to the concept of caring in this research (Watson, 1999, 2000a, 2000b; Watson & Smith, 2002).

The Therapeutic and Technological Revolutions

The 'therapeutic revolution' is a term used by Porter in a discussion on the discovery and rapid development of antibiotics around the middle of the Twentieth Century (Porter, 1997, p. 458). I have used it to designate a span of time, from the mid 1940's to the mid 1960's, indicating the importance of the period of modern pharmaceuticals and the flow on to curing disease. The Technological Revolution, with the advent of heart-lung machines, started in the mid 1960's. Both continue unabated.

Care in the Twenty-first Century

Five years into the Twenty-first Century the health care system is changing at a greater rate than ever. The ongoing Therapeutic and Technological Revolutions mean that people are now hospitalized for minimal periods, even when extensive and/or intensive care is needed: it is the 'quicker and sicker syndrome'.

In spite of technology, the sicker patient (and family) is often in need of more support and *Care*. The expectations and interpretations of *Care* by the patient and the nurse differ (A. Gardner et al., 2001; G. Gardner, 2000). Ellard (1998) in a discussion about the modern doctor maintains that:

> No longer are doctors (and some nurses) kindly people who examine you and carefully reassure you and then prescribe some simple treatment. No longer do they (nurses) have the time -nor in many cases, the inclination - to deal with the anxieties and emotional needs which could be dealt with before. Nowadays you are much more likely to remain alive; the price is often an

> unsatisfied need for magic (and *Care* from nurses). (Ellard, 1998, p. 52) (Brackets mine)

The economic reality of the modern health care system has generated systems such as Diagnostic Related Groups (DRG), and Clinical Pathways in order to discharge patients sooner. These and other systems are standardized 'tick the box' records, reductionist strategies, which for the most part ignore the real person behind the system.

Nurses have had to adapt to these changes. Increasing workloads, the impact of university education and the almost daily innovations in technology make for a working environment that is both challenging and stressful. Nurses have to deal with these changes and give the *Care* that patients expect and that the *Care* literature explicates. The decreased clinical time in undergraduate courses has meant that clinical skills have to be taught in university laboratories. Are *Care* skills being taught? Universities would strongly affirm that the theoretical notion of *Care* **is** taught.

This affirmation about the teaching of *Care* theory then leads to another observation – the gap between theory and practice is widening. It is an area that is becoming increasingly important as issues surrounding the move to tertiary-based education for nurses continue to surface. Two recent reviews into nursing education have highlighted the problems with decreased clinical time in nursing education as well as increased clinical costs and decreased clinical competency (Heath, 2002; Reid, 1994).

If *Care* is so important, it can be argued that it should/must be taught in all undergraduate nursing programs. However it can also be argued that Caring is innate and need not be taught. A large longitudinal study on *Care* in the USA indicated that the value of Caring already existed in entering students (Simmons & Cavanaugh, 2000). The argument could then be continued that as, for the most part, only inherently *Care* students enter university to study nursing, the *Care* values of students (to life in general) would simply need to be transposed into a specific capacity to show *Care*. However there is also a strong argument that prospective nursing students do not all enter nursing for altruistic reasons and consequently there is a need for *Care* to be taught (Boughn, 1999; Robertson, 1989). Moreover, the education literature indicates that values, and that would include Caring, are difficult

to teach (Krathwohl, Bloom, & Masia, 1964). The debate persists and patients (and their families) continue to have a need for *Care*.

Whichever way *Care* is viewed, it is essential for the nursing profession to ensure that patients in a time of crisis are given the clinical support and *Care* that is needed. Although the transfer of nursing to higher education in Australia is complete, the transition of nursing to being a profession is not. Nursing still needs to authenticate itself as a profession in some respects. Self-regulation, codes of conduct and ethics, and significant practice standards prior to registration are well established. The criterion of service (for the benefit of or altruism) is discussed less often (Bevis, 1989; Bishop, 1996). However, an aspect of altruism, as in selflessness, has long been considered as fundamental in the nursing profession and is exemplified in the notion of *Care*. The question can then be posed - Is there a possibility that with the transfer to universities the notion of *service* has been lost? Yet, a profession professes *service*. How best can the *service* aspect of the nursing profession (read *Care*) be ensured?

A less obvious but significant need for this research is the changing student population entering nursing programs. Some thirty years ago the profile of student entry to hospital training was female, school-leaver (usually but not always Year 12), with mothers/aunts who had nursed, and who themselves had little thought of staying in the profession. It was a logical step prior to marriage. At interview the aspiring RN would assert that she was Caring and wanted to Care for people.

A typical class in 2003 (USQ data) had fewer school-leavers, more males and also more mature age students who had completed a 'return to study course' and often a young person who is the first in the family to go to university. It is important to note that not all universities have the same student mix. The big city universities with the ability to attract the brightest and best students have without question a different student profile. This is not the case in rural or smaller universities where the above diversity is (from experience) typical. The underlying motivation for entering university is often primarily to improve their socio-economic standing. The change from the predominantly female school leaver to the current mix of students has continued steadily. The range of backgrounds has also increased. The male students have ranged from chefs to disenchanted engineering students and the females from hairdressers to a 50 years old primary school teacher who finally took the plunge and made the career change. (Personal experience) *Care* is not always a

motivating force, although it is probably an underlying factor. Many of these prospective RN simply do not know how to show professional *Care* even if they subliminally want to Care. These students need to be shown how. There is no comprehensive work on how to show *Care*. A straightforward guide in which *Care* can be transposed into the clinical environment is overdue.

The Research Questions

This research is practically motivated in that I wanted to find if there were specific ways in which *Care* is demonstrated in the present health care environment?

- What are the specific enactments/strategies/skills that are used to demonstrate *Care*?
- How can the findings of this research and the literature be synthesized into a framework for teaching *Care* strategies?

The second question, as a follow on to the first question, suggests that a teaching framework be formulated that can be used in undergraduate nursing programs. The intention is to use the *Care* enactments as evidenced in the data from the reflections of the participant researchers, the Graduate Registered Nurses.

Significantly, if nursing is to maintain the essence of nursing, then an ability to enunciate the *Care* strategies clearly and have a framework to teach these strategies is of paramount importance. Indeed if the ANRAC definition about the exclusive function of the nurse, that 'lies in a unique interplay of knowledge, intuitive and logical thought and a compassion for others' is correct then there is an obligation to ensure that the future RN know how to *Care*. (ANRAC Competency Project, 1990) In a comparative study of *Care* theorists, Morse, Borttorff, Neader, and Solberg (1994) ask a similar question, "Can caring be reduced to behavioural tasks?" They note that many of the theorists who consider *Care* as an affect believe that behavioural tasks cannot show *Care*, while there were no common set of interventions held by the theorists who considered that *Care* could be shown. (p. 38)

Organisation of chapters

Chapter 2: Literature review

The literature on Caring and *Care* is examined from four perspectives. The first section takes a sweeping view of the history of nursing and medical care up to the Therapeutic Revolution. The Therapeutic Revolution, together with the later Technological Revolution, is still current, but began with the discovery of antibiotics in the middle of last century. The second section is an examination of the current climate of health care, an atmosphere in which nurses often function under pressure to do more with less. The importance of the dollar and a cure/cure (cure is instant and there is no need for care and by definition *Care*) mentality of patients and doctors adds to the stresses of giving *Care* in the Twenty-first Century.

The literature on Caring and *Care* in the third and fourth sections is predictability selective. The literature in both these areas is wide ranging but in some cases it is very definite, such as the *Care* literature on aged care or oncology. The choice has been limited to the literature that has direct relevance to the areas of this research as well as its results. The third section takes a bird's eye view of seven writers on Caring and what is relevant in their writing to *Care*. The final section deals with the *Care* literature. There is an excursion into the *Care* literature in which three *Care* theorists are examined, followed by a selection of the research in *Care* as it relates to the enactment of *Care*.

There are references to the *Care* literature throughout the thesis and in particular Chapter 5 where the themes of the GRN reflections are analysed. In Chapter 6 there is a specific review of selected educational literature related to curricula and the setting of objectives as well as an overview of the research into how *Care* is taught in nursing.

Chapter 3: Participatory research

The philosophical approach and methodology for this qualitative research is based on the participatory paradigm, as explored and explicated by Heron and Reason (Heron, 1996; Heron & Reason, 2001; Reason, 1998). The essence of the participatory paradigm is that the lines between the researchers and the researched become blurred as they form a partnership in pursuit of a common goal.

Participatory research includes the concept that the researcher is intimately involved with the research and thus has an effect on both the research process and the interpretation of the results. The identity of the researcher is evident – a reflexivity that allows for the inclusion of my personal history of almost half-century of nursing as discussed in the Preface.

The development of qualitative research has been rapid and the notion of reflexivity in research is an important recent development (Denzin & Lincoln, 2000). 24 There are three explanations/definitions which when brought together bring reflexivity into focus.

> a conscious experiencing of the self as both inquirer and respondent as teacher and learner as the one coming to know the self with in the processes of research itself (Lincoln & Guba, 2000, p. 183).

And at the same time to be in a state of

> "critical subjectivity" (Heron, 1996, p. 127).

So that

> "the meaning of experience is derived from the inside out, rather than being imposed on experience" (Bray, Lee, Smith, & Yorks, 2000, p. 5).

Although compassion in daily living is a universal phenomenon there are differences that become apparent in philosophical discourses (and in research). These philosophical differences will vary depending on many concepts including culture, religion and race. This research is influenced by the personal stance of the researcher and is a Western, Judeo-Christian perspective – a humanistic standpoint that is congruent with much of the *Care* writers.

The design and method of this research reflects the involvement of a group of Graduate Registered Nurses (GRN) and experts in education as well as the cyclical nature of participatory research.

Chapter 4: Design and Methods

The design and method of this research is built on the Collaborative Inquiry (CI) model espoused by Bray, Lee, Smith and York, based on Heron and Reason's interpretation of participatory research methodology (Bray et al., 2000). Bray et al identify participatory research as a cyclical process in which the researchers are free

(within the restraints of the question) to follow new leads and new directions as the data unfolds in a meaning making process. The researchers in the cycles of reflection generate questions and find answers, then generate further questions in the search for a final answer. Importantly, the questions are those that are generated in the real world and "confront people in their daily lives" (Bray et al., 2000). 27 There are two participating groups, the Graduate Registered Nurses and experts in education.

The Graduate Registered Nurse/s (GRN) reflected, on how Registered Nurse/s (RN) showed *Care*. The group were graduates from the same university and had, as far as the researcher knew, imbibed a philosophy of *Care* in nursing similar to that of the researcher. The novice status of the GRN group, who had yet to become socialised into a nursing role, was perceived to be a strength of this research.

The second group was smaller and met to discuss and review the framework for teaching *Care*. There was only one meeting, but it had an influential effect on the cyclical nature of the research and the subsequent episodes of reflection and thinking.

Chapter 5: Phase I – How is *Care* enacted?

The analysis involved a systematic reading of and gradual engagement with the GRN reflections. An initial identification of the recurring themes was prepared and the reflections were inserted into the Nvivo data analysis program. The Nvivo program was used to track the identified themes. A period of further reading of the literature alternating with a return to the GRN reflections meant there was an immersion in the data. Themes were combined as the intent and absorption in the data continued. A saturation point was reached when it was felt that the intent of all the GRN reflections had been established.

The reflections of the GRN participants are used to illustrate the analysis and interpretations. The quoted reflections are in italic Arial font followed by 'GRN' and a number - the research number allocated to each graduate registered nurse. Minor spelling and grammatical changes were selectively made to the quoted reflections.

All the participating GRN were invited to join in a dialogue/discussion day to consider the findings. Six of the GRN participants indicated that they would join the group and they were then sent a summary of the findings. The group met and spent a day together reflecting on the results. The congruity of the group in their experiences

post-reflective writing and their view of the interpretations to that point was an empowering experience for the researcher as well as the participants.

The incidents that had been recorded were acknowledged as being part of their experiences – although the incidents of the *Care* were universal. The interaction in this representative group, who did not know each other, enhanced the credibility of the interpretations. The overarching emphasis on individualising patient care was evident. The literature on *Care* was incorporated into the validation of the interpretations affirming the importance of the enactments. There was an almost seamless continuation into Phase II as the development of the framework began to be formulated in preparation for the meeting with the experts.

Chapter 6: Phase II – A framework for teaching?

A framework to teach *Care* was generated, the Professional Personalised Car* (PPCar*) framework, using the findings of the reflections and the Caring and *Care* literature. This was then given to an expert group of three lecturers in nursing and education who met to review and discuss the PPCar* framework and provided feedback to the researcher.

A brief exploration of the educational literature and research into the teaching and learning of *Care* ensued. A two-month break overseas was significant in that I put my research 'to bed' for that time. The return to the research involved seeing the literature and the PPCar* framework with renewed vision.

Chapter 7: Phase III – Reflection-on-reflection

Phase III involved a process of reflection-on-reflection, a higher level of reflexivity (Bray et al., 2000) and explanatory reflection (Heron, 1996), by the researcher. This was the only time in the research process where the researcher was the lone participant. The individual chapters were returned to with a specific focus on the reflections that had been made throughout the research process. In particular, the interpretations were revisited and reviewed. The limitations of the PP*Care* teaching framework were evident and there was a need to re-conceptualise it. The centrality of the patient had been lost and the link between Active Interest and the and the way *Care* could be shown had been overlooked.

Chapters 5, 6 and 7 begin with a cameo of the chapter and the model of the cyclical process with the relevant phase highlighted.

Chapter 8: Conclusions and recommendations

The concluding phases of the research were a fresh challenge to me and the conclusion focused again on the importance/centrality of the patient and a new model of *Care* was generated. In the present clinical milieu, therapeutic 'relationships' are different, and patients need a different kind of Caring, a professional *Care*, that is as adaptable to the patient and their families as can be. This model of *Care* Connections can be adapted to form a teaching framework as well as serve as a model for management in the clinical milieu. It can also serve as a model of *Care* for further research.

Chapter 2: Literature Review

Introduction

Caring, and more specifically this research into how *Care* can be enacted, cannot be studied in isolation but must be explored in juxtaposition with interlinking, almost inseparable, concepts that have influenced nursing practice across the centuries. These influences, that have only recently become a spent force, are the Christian imperative, the devastating course of disease, and the search for a cure. Antipathies to things religious and fiscal pressures have largely replaced the Christian imperative and the search for a cure has become a search for immortality.

The literature on Caring spans the centuries and now also includes a significant volume of literature on *Care*, thus this review must be selective. The choice rested with the researcher and the cyclical nature of the participative methodology; therefore the review of literature is not limited to this chapter.

This review is divided into four parts. The first two parts are practical and explore the milieu of *Care*. In the first instance, the historical aspects of the 'who' and 'where' of *Care* as it was purportedly practised, interpreted by nursing historians, is highlighted. This is followed by an overview of the present climate of health care in which *Care* is carried out, as it is a rapidly changing one that creates tensions and impacts on *Care* relationships. The third and fourth sections deal with theoretical approaches to Caring and *Care*. A limited selection of philosophers, theologians, psychologists and psychotherapists are used to give a broad perspective on Caring. Finally there is a discussion on a selection of the *Care* literature.

The Past: a slice of history

The farthest reaches of time

> From the farthest reaches of time, in the most primitive settings, the *nurturing efforts* and independent role of the nurse in response to survival needs were directed toward keeping people healthy as well as comforting the sick (1973, p. 30). (Italics mine)
>
> …the evolution of the role of nursing in the history of mankind is truly monumental because our primitive ancestors left no record of their *art of nurturing* except for the indisputable fact of the survival of the human race (Dolan, 1973, p. 1). (Italics mine)

Caring in nursing is a presumption reiterated in history of nursing texts. Josephine Dolan's *Nursing in Society - a historical perspective* (1973), is not an exception. Published in the hundredth year of the graduation of the first nurses in the USA, it is the 13th Edition, and is the 'successor to Miss Goodnow's many editions of Nursing History' first published in 1916 (Dolan, 1973, p. 209).

There are some that would assert that it is a tautology to say that *Care* is intricately bound up in the history of nursing. Superficially this appears to be correct. For the most part nursing is portrayed as a dignified and gracious occupation in which nurturing and caring is significant (Baly, 1997; Calder, 1955; Cordia, 1990; Dolan, 1973). Mary B Mallison encapsulates this view on the dust cover of Donahue's *Nursing, the finest art*, "The power, the sacrifice, and the beauty of nursing come alive in this book. Its pages reflect the passage of nursing from ancient to modern times with all the joys and sorrows that were part of this long journey" (Donahue, 1985). It is left to the reader to work out what the sorrows are as the focus is on the achievements of nursing. The emphasis is on the 'beauty' of nursing and the sense of vocation that do not reflect on the 'sorrow' and the hard physical work of the physical care that predominated much of care. Sorrow too, in the helplessness of epidemics and the certainty of untimely deaths of family and friends. I posit that historically this *Care* is a misnomer.

It is possible that there was little, if any, disease in the modern sense of the word although injury, infections from soil, and local infestations of malaria must have occurred. In general terms the health of primitive man, concentrated in small communities, was relatively good. Dobson, in a discussion of early civilisation, maintains that it is probable that there was little sickness. Communities were small, early civilisations did not have the populations to support many of the epidemic disease, and travel, except for the contact with close neighbours, was unknown (Dobson, 1997). Indeed, Calder's small history of nursing text is possibly right when the 'present-day nurse' is depicted as being a 'descendant of a long line whose history goes back to antiquity' and that indeed the first nurse was the 'first mother'. (Calder, 1955, p. 2). It is the history of nursing as I was taught it. It is also possibly a reflection of the position of women at the time of publication. Although nursing and teaching were the only careers open to women, nursing was also considered a 'suitable' occupation to prepare young Caring girls for motherhood.

However, as the nomadic way of life of early civilisations became settled and agriculture "rescued people from starvation, it unleashed a new danger: disease" (Porter, 1997, p. 18). Porter does not comment on the way in which the new danger was dealt with. It is certain that in early civilisations health/sickness care was centered in the community/household - there was nothing else. Nursing history depicts the first carers (nurses.) as the wives/mothers who over time accumulated wisdom in the care of sick and wounded and did this with "loving compassion" (Dolan, 1973, p. 2).

It is indulgent to assert that the Care element in early civilisation was implicitly, unfailingly present. There are times when 'recorded' history unfolds to reveal periods of suspicion, fear and magic as man alternatively fought against or accepted the environmental threats of disease and injury as they struggled with the unknown forces of punishment from their 'gods'.

Without doubt, all means at the family's disposal would have been used to procure a 'cure'. Early archaeological findings indicate that the first forms of 'treatment' were probably amulets and fetishes worn to ward off disease or the evil spirits that caused disease and in this respect early attempts at prevention were easier than the 'cures'. There were also early endeavours at 'cures' for physical illness and injury. These are evident in the primitive 'instruments' that have been found, and skulls of early periods of prehistory indicate healed trephine 'holes' and fractures. Who lived? and Who died? as a result of shock and sepsis was simply in the lap of the gods. (Porter, 1977; Donahue, 1985). It seems that little was known about the cause of disease and cures were either providential or simply an end result of the natural course of the disease. One can safely assume that there must have been Caring. Communities were small and so the relationships must have been close.

Donahue (1985) describes early primitive medicine as being a "mixture of magic, religion and naturalistic medicine" (p 21), and Porter sums up the totality of the history of medicine as being "like the night sky: we see a few stars and group them into mythical constellations. But what is chiefly visible is the darkness" (Porter, 1997, p. 13). The burden and dominance of disease were simply a factor of life at the time. What care or Caring there was, is open to speculation, although the history of nursing would have 'us' believe otherwise.

The sanctification of the history of nursing is not an erstwhile phenomenon. That it is still prevalent is the special exhibition of nurses and nursing in art held in

the Philadelphia Museum of Art (in association with the Centre for the Study of the History of Nursing, University of Pennsylvania School of Nursing) in 2000. The introduction in the catalogue sums up the perceptions of some academics in nursing and possibly the public in general, that the pictures and artefacts "give abundant visual evidence of the care, nurture, and support nurses have always given to society, and honour their continuing commitment to the betterment of all" (Helfand, 2000, p. 7).

Jocelyn Lawler (1995), in her forward to an edited book on scholarship in nursing, comments that the debate of what nursing is and how nurses nurse has already been addressed. There is nothing to suggest where or how this has been done and Lawler suggests that it is time to move forward to a more scholarly approach concerning other issues, and that there must be a "willingness to explore troubling and troublesome questions about our philosophical roots" (p. vii). Are these philosophical roots imbedded in the history of nursing? What is it that needs to be explored in order to gain an understanding of the *Care* that is purported to be synonymous with nursing? Rafferty comments that, "until the early 1960s, the writing of nursing history was dominated by nurses and nurse leaders who used history as a vehicle to justify professionalisation" (Rafferty, 1996, p. 175). She too does not elaborate on her thinly disguised criticism of nursing history.

Aegis and the Christian perspective

While researching the etymology of caring, an early form of the word care - 'aegis' came to light (Hank, 2000). Protection, shelter, and aid are synonyms for aegis. Aegis incorporates the notions of using whatever was available to alleviate the pain, discomfort and suffering of the dependant. Effective medications were few, and disinfectants, deodorises and pesticants were unknown. The accoutrements of daily modern life that we take for granted did not exist. Clean bed linen as and when needed was a luxury that was largely unknown. Under these conditions the care of the sick would have been demanding and physically hard work. Helpless to do much other than offer physical comfort it would have been emotionally draining. It was aegis.

The word aegis begins to have important meanings in light of the discussion on the limitations of the history of nursing and the lack of cure. The nurses were in many ways not nurses as interpreted and inferred in the history of nursing texts.

They were carers and cared for the dependent, babies, sick, injured, elderly and poor. Nursing was a time-consuming labour of necessity and the *Care* simply – aegis.

In the pre-Christian era there were only two alternatives: the rich were able to buy aegis, the poor had no choice but to take care of their own. In the post-Christian era there was a third alternative, aegis became an imperative of love. The dependant sick were under the aegis of whoever was consigned to aegis.

The notion of patronage (another synonym for aegis) is particularly relevant. The early Greek and Roman matrons who sometimes feature in the history of nursing were more often the rich benevolent donors rather than the sacrificial carer. Aid would have been in the form of protection and shelter; often it was all that was available.

The Old Testament Jewish faith in a single, loving, just God who heard and answered His people was different from their neighbours who worshipped multiple gods. Grippando and Mitchell (1989) point out that, within the confined world of the Old Testament, "In spite of affluence and riches, pagan ideals prevailed and little value was placed on human life until the time of Christ" (p. 4). The Old Testament interpretation of disease is one in which disease and death were a punishment for sin. Although there were laws for the prevention of disease (food codes and sexual restrictions) and treatment of leprosy/disease (exclusion from the camp or settlement) the end result was primarily death. The cure part of the equation was a rarity although divine intervention, as in the Biblical account in II Kings of Hezekiah's leprosy and the Genesis account of Sarah's infertility, did occur (Peterson, 2002).

The advent of Christianity brought new hope and a message of love to the homeless, bereaved, indigent and sick. The Old Testament theme of justice was replaced with the central theme of love and forgiveness in the New Testament. This changed the way in which people viewed themselves and, more importantly, others. The message of the Gospels was to 'love one another' and to 'do to others what one would want to be done to yourself'. The New Testament (Peterson, 2002) had a new message, taught through the parables such as the Good Samaritan, and the direct teaching of Jesus. The sick and homeless were in essence, Jesus himself, and his teaching was very direct.

I was hungry and you fed me,
I was thirsty and you gave me a drink,
I was homeless and you gave me a room,
I was shivering and you gave me clothes,
I was sick and you stopped to visit,
I was in prison and you came to me.
And that,

"Whenever you did one of these things to someone overlooked or ignored, that was me - you did it to me" (Peterson, 2002, p. 1797).

For centuries it was the maimed and diseased who were 'overlooked or ignored' as the superstition and fear of contracting the illness resulted in the ostracisation of the ill and suffering. It was the healing ministry of Christ that prompted the early deaconesses' care for the sick and the dying, and Donahue is expressive in her short paragraph on the impact of the teachings of Christ on the "systematic development of organised nursing", calling the nursing work which they did a "marvellous activity of love and mercy" (Donahue, 1985).

For the next fifteen centuries it was the Christian imperative that was the motivating force to take care of the homeless, widows, destitute, and social outcasts in the Western world. In the mid-sixteenth century the materia medica of the day was comprehensive and there was a general belief that it was a symbol of God's providence that each disease had its own cure derived from medicinal plants (Park, 1997). In addition to this, Park also discusses the fact that there was an "easy coexistence between natural and divine healing" with saints and churches as part of the essential healing practices that were available to those seeking some cure for the disease (Park, 1997, p. 70). Monastic and secular religious orders proliferated and continued with good works through to the Reformation. Although there was a decline in the strength of the commitment of the church to the care of the needy, it was still a force within society (Donahue, 1985; Park, 1997).

In a discussion on the origins of nursing and of hospital care, Grippando and Mitchell assert that, "It is not likely that organised nursing existed before the birth of the Christian church" (Grippando & Mitchell, , p. 2). However they also make the point that monastic nursing and medicine had little scientific basis and that the care of the sick was largely a comforting one in which prayer for "saintly intervention" was important (Grippando & Mitchell, 1989, p. 5). This somewhat negative view is

tempered with other interpretations such as Park and Summers. Park (1997) asserts that the hospitals were "relatively effective" and "well managed" and that they afforded the poor free access to the best level of care that was available at that time (1997, pp. 69-70). Summers (1997) is disapproving of nursing historians who are at times not sympathetic to the religious orders, indicating that they (the orders) had an 'indiscriminate mission to care'. However, Summers is emphatic that the religious orders "set themselves goals of cleanliness, with elaborate procedures laid down for washing and delousing the bodies and heads" and that they were "often reaching higher sanitary standards than those previously known to the sick poor". The religious model of care remained through to the sixteenth century a model which was difficult to improve on (Summers, 1997, p. 194).

It is against this background of 'patronage', 'aegis' and a religious vocation to join a Holy Order that Florence Nightingale took centre stage. The thankful public sanitised her role in the Crimean war and the notion of 'vocation' and 'devotion' outside the Catholic orders took hold. *Care* was a given.

Physical caring is assumed in the history of disease and illness and the tender loving care, as the Christian imperative, is implicit in the history of nursing. The dominance of disease became a factor that influenced the care of the sick as civilisation progressed from small rural communities and villages to larger towns and cities.

The dominance of disease

At times disease dominated the lives of people as the epidemics of recorded history wiped out large percentages of communities. Some 50 million Europeans are believed to have died of plague in the epidemics of the fourteenth and subsequent three centuries (Dobson, 1997). The impact of a disease on virgin soil populations has been documented as recently as 1874 when it was estimated that a quarter of the population in Fiji died from measles (Porter, 1997). Who nursed these patients is open to speculation. The 'nurses' – mothers, relatives, neighbours - would have been vulnerable and often succumbed to the disease as well. Be that as it may, there was often no need for long periods of nursing as the acute diseases killed quickly. The details have been lost in the mists of time.

Diseases such as the plague, cholera, smallpox and diphtheria would all have been feared. Caring and care in these situations would have been a labour of

necessity and sometimes love as often the carer would have been either unwell (in a prodromal period) or recovering (in a weakened state from the disease) (Porter, 1997). Disease was not the only mortality factor in the middle ages. "Lethal famines" occurred in England until the late Sixteenth Century and in continental Europe up to the middle of the Eighteenth Century (Porter, 1997, p. 237). The lack of adequate food supplies would have made 'nursing' difficult for the malnourished carers and hastened death for those who had succumbed to disease.

Life expectancy was short. In France, before 1750, infant mortality was over 200 deaths per 1000 live births and "unidentifiable fevers killed perhaps 40 per cent of Europe's children before the age of fifteen" (Porter, 1997, p. 237). The tragedy of disease and death in the centuries prior to the medical advances of the mid-Twentieth Century are best summed up by Dobson in a discussion on disease ecologies,

> There have been times in the past when there were not enough able-bodied to care for the sick and dying, when large numbers of infants have been abandoned and orphaned, and cohorts of young adults have been severely depleted for generations to come (Dobson, 1997, p. 179).

It is difficult to understand or even comprehend the anguish of parents losing their family in a matter of weeks as child after child died from diphtheria. Caring for each successive child as they succumbed to the infection would have been wearing to the point of exhaustion, and to bear the sorrow and know that the next child would most likely die as well would have made the care difficult and the Caring beyond imagination.

The only known way to cure was to isolate. This was an extension of the earlier notion of prevention, when amulets were worn to ward off disease. Isolation would prevent the spread of the disease to other members of the community and was probably done with inhumane precision. Exclusion from the community, or removing oneself from the community, has been practised for thousands of years. In a number of communities lepers were forced to live outside the community in order to prevent the spread of the disease and in other tribes the whole village or settlement were treated, as well as the patient (Dobson, 1997; Porter, 1997).

Lazarettos for contacts with smallpox patients, lunatic asylums for the psychiatrically disturbed and leprosaria for the leprosy sufferers became an essential

part of dealing with the infectious diseases. Usually built on the outskirts of the town or away from heavily populated areas, the inmates were for the most part given minimal attention, as the patients were outcasts, untouchables or mad. These establishments were implementing a modern version of the Old Testament principle – the patients were being 'expelled' from their community.

The histories of nursing and medicine have a common root, disease, and it is unnecessary to divide the two. Disease dominated. For the patients 'stricken' with the diseases that plagued mankind until the middle of last century, it meant either a quick death or a difficult and sometimes painful disease trajectory. Stricken, a word not in common usage, is an old English word that adequately describes the attitude to those who had contracted some sort of disease for which there were no known cure. Caring for the physical needs, preventing the spread of infection and a spiritual preparation for death was all that was available. A single adjective in relation to disease would have been 'S-cared'. That tender loving care was part of the equation is open to supposition.

Nineteenth to the mid-Twentieth Century – health, hospitals and nurses

What is known is that for the majority of the diseases there was no effective cure. In fact Sax (1984) notes that,

Until the beginning of the present Century, medical care did not play a significant part in reducing mortality. (p.226)

Health

Disease continued to dominate. A title for this period could be, 'to care always and sometimes to cure'. In spite of some advances in treatment, medical care remained in the 'dark ages' and cure was unscientific, often a 'hit and miss' affair. Religious and social mores had prevented the dissection of the human body and although advances had been made, technologically the management of disease remained at the bedside. The microscope was invented in 1600 but it was not until the 1860s that the connections between bacteria and disease were established and bacteriology became a science. The obstetrical forceps, first used at about the same time, remained a family secret for generations. Laennec first used the stethoscope in

1819 in order to remain 'distant' from his patients (Porter, 1997). There were few medications available to control symptoms such as diarrhoea and vomiting; and to add to the misery of the patients if they did not have diarrhoea or vomiting, they were induced as part of the cure.

There was a divide between informal and formal medicine, apprenticeship and quackery. As universities multiplied it was often the wealthy that went to study "medical improvement", a blend of art and a little science. The focus of the art was to improve character and a sound value system while the science of disease was largely theoretical (Rosner, 1997, p. 147). Physiology and pharmacology were for the most part 'guess work'. In the late Nineteenth Century there was still opposition to the use of animals in medical experiments hampering the advances of medical science, in particular the study of hormones and the understanding of physiology (Tansey, 1997). Attempts at curative procedures were largely surgical (without anaesthesia.). The patient still had to survive the postoperative sepsis. Medical care consisted of the common 'fad' that was sweeping the medical fraternity at the time. Rarely was a full examination done as the mores of the time did not allow undue exposure of the body (Porter, 1997).

Although an anaesthetic was used for the first time in 1844, 'Safe surgery' had to wait another 50 years until Lister's introduction of antiseptic and later aseptic surgery (Loudon, 1997, p.320). Safe surgery, as it is known today, is a phenomenon of the present. As recently as the 1930s, tonsillectomy in England resulted in over 80 children dying each year from what today is a simple procedure (Porter, 1997, p. 601). The maxim to 'comfort always' was gradually being lost. It appears that in the interest of research and the development of techniques, procedures were continued that were not in the best interests of the patient. The improvements in health and reduced mortality during this period were due largely to better standards of living (food and sanitation) (Sax, 1984).

Porter (1997) tells of the limitations of medicine prior to the discovery of the modern drugs. Reflections of a medical student of the 1930's recall that the Useful Drugs text that the students carried around in their pockets was a slim volume with only 100 pages. Synthetic 'Aspirin' had only been discovered at the end of the Nineteenth Century and was often used as a panacea for a wide range of conditions. The story is then told of a doctor who kept three large bottles of aspirin in his consulting rooms. The 'Aspirin' had been dyed green, pink and yellow. These

coloured tablets and a bitter liquid formed the backbone of his prescriptions; the therapeutic value was in the consultation and his Caring interest in the patient as a person (Porter, 1997). The therapeutic value 'in the mind' of the patient continues…even with the modern antibiotics.

In 1926 a Health Commission in Australia was instigated, as, among other things, "maternal mortality was so high" that it was considered to be a "grave national danger" (Sax, 1984, p. 38). This is in spite of the development of anaesthetics and antiseptics. Modern medicine was in fact still in the Dark Ages…so too, were the hospitals and the duties of nurses.

Hospitals

Care remained in the home as hospitals were built for the orphans, insane, elderly and people with 'communicable diseases'. The caring family doctor remained grounded in tradition, at the bedside – in the home. The Enlightenment and the steady increase in scientific knowledge had left medicine behind. The notion that 'nurses care' and 'doctors cure' is essentially a modern phenomenon. The fact that doctors maintained the maxim 'to cure sometimes, to relieve often and to comfort always' for many centuries seems to have been forgotten in the present literature on *Care*.

It was only in the last third of the Nineteenth Century that hospitals devoted to the treatment of disease were founded (Trohler & Prull, 1997). However, Nightingale was adamant in her belief that patients should be nursed in their own homes (Baly, 1997). (It seems though that only the wealthy had the luxury of a family nurse and were able to nurse children and ailing members at home.) That Nightingale thought hospitals and infirmaries should be abolished was possibly with good reason. Porter cites from Robert Morris' reflections written in 1930 on his 50 years of practice in the USA (unreferenced) that few people wanted or would go to a hospital. Hospitals were places that one kept out of and the word itself carried denotations of "pestilence and insanity" (Porter, 1997, p. 381). Indeed, hospitals, homes and communities differed with the surrounding historical happenings of the time. The development of the modern hospital had to wait until the Therapeutic Revolution and scientific treatment, which in turn paralleled the development of professional nursing; up to that point in time there were few specific skills involved in patient care (Trohler & Prull, 1997).

The isolation precautions to prevent the spread of disease continued but were not limited to the known communicable diseases. The fear that accompanied infectious diseases were also apparent in the negative attitudes to mental diseases which were so strong that it appears even family were not prepared to care for their own. The numbers of people committed to Bethlehem hospital (the notorious Bedlam) and other asylums affirms this. The comment that, the inmates were left to the "dubious ministrations of untrained and often thuggish attendants" is telling, probably reflects the nursing of the times as well (Porter, 1997, p. 500). Enormous changes have been made since then but negative attitudes still exist in the community, as evidenced by the reactions of neighbourhoods when it becomes known that a house has been bought by the mental health sector for de-institutionalised clients.

At the beginning of the Nineteenth Century sanatoria were built for those who had tuberculosis. Although a communicable disease, the primary (and only) form of treatment was rest and a nourishing diet. The wealthy in England went to the mountains in Switzerland and, although the treatment was harsh, the privilege of being able to afford foreign treatment and the good air of the mountains made the treatment acceptable. The poor were sent to one of the forty-one sanatoria governed by martinet superintendents, "dustbin(s) where the dying could never again infect family and workmates" (Porter, 1997, p. 423). Tuberculosis sanatoria continued well into Twentieth Century and the care improved, and as the patients were long-term, so did the *Care*. A colleague reminisces about his mother who had tuberculosis; she was in hospital for a long time … a year or more. She often used to talk with fondness about the nurses.

A snapshot of the hospitals, available 'cures' and some insight into the work of nurses of the time can be found in the 'new' nursing text published in 1944 (Doherty, Sirl, & Ring, 1954). The procedures and duties were not new; they were simply being published for the first time. These procedures were many and various and most of little value. Enemas (of all descriptions), antiphlogistine and mustard poultices, Counter Irritant Baths (half an ounce of mustard to every gallon of water) for convulsions, Cantharides Plasters (to blister the skin) and boiling of infected faeces (if the Chloride of Lime was not available) are all carefully detailed (Doherty et al., 1954). They were part of the treatment and hoped-for cure indicating how in

essence medical science remained in the Dark Ages until the middle of the Twentieth Century.

It is sobering to reflect that the text is just 50 years old and that some current RN had 'Doherty' as a text. Pain relief was not always available, or effective, and some of the cures that doctors offered were decidedly uncomfortable and sometimes lethal. Purging, leeches, and bloodletting would have been, in addition to being uncomfortable, decidedly frightening and again for the nurse/carer – hard work. The *Care* is not mentioned.

Nurses

In an overview of the history of nursing in Australia, Happell notes that formal nursing began with the arrival of the Sisters of Charity in Sydney in 1838 and the Nightingale nurses, led by Lucy Osburn, arrived 30 years later (Happell, 2001). What is not indicated is that there were only five Sisters of Charity and only three were trained nurses. In 1836 the population of Sydney was 19,000 and those who needed attention (nursing care) received care from the convicts, female and male. There were three levels of female convict labourers, and it was the lowest third that were assigned nursing duties. Nursing was "dominated by domestic tasks" (Happell, 2001, p. 379). It is thought provoking that the domestic tasks continued for over a hundred years. The history of two of the largest hospitals in Australia clearly indicates that this is, even in part, true (Cordia, 1990; Templeton, 1969).

An interesting insight into the nurse at the turn of last century is given in the history of the Prince Henry Hospital in Sydney. In 1900 the second year probationer nurses received five shillings and nine pence a week. The first year probationers did not receive any remuneration at all (Cordia, 1990). Prince Henry Hospital in Melbourne was similar, and perhaps because there is more detail available, conditions appeared to be worse than those in Sydney. In one of the rooms on the top floor of the Nurses Home of 1910 a nurse slept with an umbrella over her bed as the roof leaked. This building was only rebuilt in 1950 (Templeton, 1969). Elizabeth Burchill, in her autobiography, tells of the hard work and the evening meal of soup, bread, butter and jam that were part of the austere diet. She did the midwifery course of six months in the mid 1920's, working twelve-hour shifts, receiving no salary (Burchill, 1985). Lectures were in off-duty time, a practice that continued well into the 1950's.

The nurses were there to care for patients, and it is not known whether they were there as a vocation or to get away from a family situation or unrequited love. The long hours of work and the appalling living conditions were hardly the reasons for their dedication in remaining, often for many years. *Care* was undeniably there. In the long hospital stays that were normal at that time, patients and nurses probably formed what are now called therapeutic nurse-patient relationships that were satisfying for the nurses and sustaining for the patients held 'captive' for many months.

The 'thoroughly dependable' nurses of 1885-1936 are described in the history of Prince Henry Hospital (Melbourne). It was a period that began with the commencement of the two-year training and although it is not specified, ended with the embryonic beginnings of the Therapeutic Revolution. Templeton's (1969) description of the nurses and their conditions is too detailed and cannot be given here. However, a snapshot of the nurses indicates: The "selfless dedication" of nurses (as something beautiful and not be corrupted by sordid monetary considerations) was a phrase frequently bandied round by hospital committees as an excuse for not raising their salaries, it was not, for all that devoid of meaning. This dedication was evidenced by nurses who "devoted to their patients", "regarded them as her personal responsibility", and many "recovering from careless or septic surgery owed his survival to careful nursing." The nurses had a "closer relationship with their patients than is possible today." Finally Templeton notes that "a nurse with half a day off a week was quite capable of foregoing even that if it meant leaving a patient who was very ill." It is inconceivable to think that these nurses gave up what must have been precious off-duty time. However, Templeton attributes these attitudes and values of the nurses to the quality of the nurses as well as the smallness of the hospital and an absence of pressure. Templeton goes on to justify the nurses of her era (the 1960's) by noting that, "This view does far less than justice to modern nurses, of course. Patients are watched with great care and devotion today, but of necessity is by several nurses rather than by one" (Templeton, 1969, pp. 135-141).

In 2005 there is no possibility of forming the strong personal and 'professional' relationships that would have been forged when patients spent months in hospital, over seven decades ago, and Watson's philosophical caring 'moment', is nearer the truth (Watson, 1999). Even five decades ago, when patients spent ten to fourteen days in hospital, professional relationships could be formed. Hospitals (as

well as hotels) are in many ways a service industry where the client/patient/customer reigns supreme. The sovereignty of the patient is an important consideration in ethical interpretations of individual rights (Johnstone, 2004).

Olsen's (1993) research in the USA, on student evaluation, covers much the same period as Templeton's historical account and gives a clear picture of nurses as perceived by their supervisors. Using a thematic analysis of the language in the evaluations of 538 nurses, 1915-1937 at St Luke's Hospital, Minnesota, Olsen found that there was no mention of *Care*, or even the then equivalent words such as nurturing or comforting. The words, handling, managing, controlling and finished work (*neat and tidy*.) were the predominating themes of the reports, often seeming to indicate that the nurses were strong and capable (*and able to work hard*). There is a strong case made that the concept of *Care* as it is currently articulated is absent, and that doubt is cast on the tradition of *Care* (Olson, 1993). Olsen's analysis is in the qualitative domain and the interpretation is one which is central to the emerging debate about the essence of *Care* and how much of *Care* is a modern phenomenon. Even a superficial comparison of Templeton and Olsen leads one to the conclusion that nursing was not easy and that distance lends enchantment, further evidence of the sanitisation of the history of nursing.

Twenty years later it seems that little had changed. A colleague found a copy of the form used to evaluate nursing students in the mid 1950's at St Luke's Hospital, Sydney. It reflects some of the concepts used at St Luke's Hospital, Minnesota, in that the nurse had to be appraised, amongst other things, on Appearance, Punctuality and Reliability. It is a tick-the-box type of form with 'Appearance' being very neat, fairly neat or untidy; or whether the Handling of Materials was economical, fairly careful or wasteful. Although there is no reference to comforting or *Care*, there is space to appraise the Personality – wholesome, ineffective, or negative and the Approach to patient could be either, friendly and outgoing, vacillates, or is unsympathetic. The word 'unsympathetic' is also used in the section referring to the attitudes to relatives and ministers of religion. The only reference to the modern *Care* is there, but in a most unusual way – negatively, in the word, unsympathetic. A further anomaly that contradicts the teaching of that time, 'not to get involved', appears in the section labelled 'Approach to patient' with an option to tick, 'Friendly and outgoing'. It is an unusual phrase in a clinical evaluation of the time (Appendix 3).

Minchin (undated), in a history of the Victorian Nursing Council, quotes from Minutes of the Nurses' Board (1925) when the board was struggling to set educational standards for nurses. The board was accused of being too ambitious as all that nurses required was "a little human sympathy, a great deal of common sense, and sufficient technical skill to give an enema". A 1936 British Medical Journal deplored the fact that nurses were being taught anatomy and diseases which were "utterly irrelevant to the nurse' duties" (Minchin, undated, p. 103).

Nursing remained predominantly physical. In 1974, when the transfer of nurse education to universities was being vigorously debated, the role of the practical and essentially physically caring nurse was still firmly entrenched in the nursing profession. "It is my firm and basic belief, that nurses at basic level do not belong in universities" (Wiles, 1975, p. 8) and "The aim of first-level education should be to produce skilled practitioners in the art of nursing and not scholars" (Cowell, 1975, p. 10). It was to be twenty years later that the scholars' debate on the art and science of nursing became a serious academic exercise (Chinn, 1994; Dunlop, 1986; Lindeman, 1999; Paniagua, 2004; Parker, 2000; J. S. Taylor, 1997).

The Therapeutic Revolution and two reflections

The Therapeutic Revolution is a term used by Porter (Porter, 1997, p. 458) in a discussion on the discovery and rapid development of antibiotics around the middle of the Twentieth Century. It started slowly with the 'new' medications, some 70 years ago as the "Sulpha drugs marked the dawn of modern treatment" (Porter, 1997, p. 685). Loudon (1997) uses the term as well and specifies the dates as being from 1945-1985 and includes the drugs used for psychiatric disorders and the contraceptive pill. This revolution is succinctly summarised by Sax in his comment that "Clinical medicine became increasingly *triumphant* after the discovery of the sulphonamides in 1932 and the *subsequent tide* of therapeutic substances" (Sax, 1984, p. 226). (Emphasis mine)

This revolution that allowed medicine to become 'triumphant', spanned some thirty years and can be divided into two categories, soft technology like pharmaceuticals and hard technology such as the development of the heart-lung machine in 1953 (Loudon, 1997) and the use of ultrasound during pregnancy. The development of therapeutic substances has been the most pervasive and it would be almost impossible to find someone in 2005 in any Western country who would not

have had some form of medication prior to his or her first birthday. What are not always remembered, are the problems that were associated with some of the new discoveries, such as foetal abnormalities in Thalidomide, and nerve deafness in Streptomycin.

Hospitals became safer as a result of discovery of antiseptics and a better understanding of the germ theory and were no longer feared. The early antibiotics such as Penicillin could only be given intramuscularly, usually three hourly. This necessitated hospitalisation, usually the length of a course of antibiotics. The advent of the Therapeutic Revolution transformed the function of the hospital from being a place where the suffering patient was cared for, to a place where treatment for the cause of the suffering was addressed. In addition, the hospital took on the role of research and teaching (Ulrich & Cay-Rudiger, 1997).

A less noticeable but important change in the perception of sickness care began in the late 1970's. Sax (1984) discusses this change. The Australian Prime Minister, in announcing the Hospitals and Health Services Commission (primarily to investigate costs and insurance), emphasised the importance of health as a community affair. Sax notes the new initiatives that "Communities must look beyond the person who is sick in bed." The commission recommended looking beyond hospitals to community based health services and "the sponsoring of preventive health programs" (Sax, 1984, p. 103). This was the beginning of the movement to provide immunisation, early detection of disease and a focus on improving health and preventing disease by community based services. They were to address 'personal habits', and 'reduce adverse conditions and environments'. Sax, the chair of the commission, comments thus on the report, "It elaborated a model set of arrangements for the provision of health services, and fostered the idea that individual service components should relate to each other within a systematic and comprehensive framework" (Sax, 1984, p. 104). This model is still being followed, albeit with limited success. Water fluoridation and greater access to dental care has seen better dental health across the lifespan, while smoking continues to lead to high incidences of lung cancer.

While the Therapeutic Revolution and the focus on health is seen as a part of medical history, the impact on nursing was and continues to be all encompassing. Tepid sponging has been replaced by paracetamol and antibiotics; skilled post-operative care has been replaced by day surgery; even the application of the roller

bandage that needed considerable skill and practice to apply well, has been replaced by tubular and non-irritant adhesive bandages. Medications are for the most part oral, taken in the comfort of the patient's own home. Severe infections sometimes still require hospitalisation, primarily because the antibiotics are given intravenously, although here too a patient may remain at home with a domiciliary nurse calling in twice a day to administer the dose. The dynamics of being a patient have also changed forever. Solicitous family, friends, and neighbours are out at work and the patient is often at home alone, nursing their disease or injury until the therapeutics 'kick in' and they can return to work themselves. Nurses deal with patients who are sicker and leave hospital quicker.

Two reflections

Although the Therapeutic Revolution is part of history, it is recent - recent enough for many nurses, myself included, to have been a part of the evolution. Nursing in the third quarter of the Twentieth Century was both exciting and rewarding. Exciting as nurses participated in a new age of medicine and rewarding as patients for the most part went home well. The historical influences on *Care* are a vital part of today's pre-occupation with *Care*. I posit that the way *Care* is shown at the beginning of the Twenty-first Century cannot be the same as the *Care* of that time.

The two reflections on the *Care* at that time are important to the background of this research. The first reflection is mine and the second is from a chance encounter with an RN.

REFLECTION I – mine

> As junior nurses we longed for the day when we would be senior enough to 'do' the medication round. Injections! Often every patient had to have an injection at least daily, and sometimes twice daily or even three hourly. Without the new wonder drugs the patients would have died. At the beginning of the Therapeutic Revolution antibiotics could only be given intramuscularly. The patients were deeply grateful for the painful 'jabs' and went home relatively well. (We take all this for granted as we swallow our oral antibiotic

in the comfort of our own homes.) The mix of patients was such that although some were critically ill, there were some who were recovering, and some who were almost well. The average length of stay was probably close to two weeks. The Nightingale wards were long and gave little or no privacy for the patients. Although we worked hard, there always seemed to be time to chat to a special patient or chat up a personable eligible male. Not me. I wouldn't have dared. I was not bold enough as such behaviour was frowned on. The code was simply that every nurse took an active interest in every patient.

Was this a special time of Caring in nursing? As I reflected and pondered I wondered if this was seeing the past through rose-tinted glasses, or 'things were better in my day' syndrome. It probably remained until the advent of oral antibiotics, and the move to tertiary education for nurses. It was a period that spanned some twenty to thirty years.

I had a chance encounter with a RN (turned horticulturist) who has maintained her interest in nursing and recently spent time in a Third world country in midwifery. I had not given much thought to some of the deeper implications of what I was calling The Golden Age of *Care* until I met the horticulturist/RN at a visit to an ABC Open Garden and a sudden short hailstorm sent us looking for shelter. We stood under the bullnosed veranda 'shouting' at one another. Caroline is an ex-RN whose husband had recently been in hospital and we talked about *Care*. Caroline told me she had been thinking a lot about "caring" since her husband's hospitalisation. This is her reflected philosophy as she told it to me and with permission I retell it.

REFLECTION II – Caroline

We all used to get into each others' rooms and share the good and bad things that had happened to us during the day. Being away from home was not a problem. We had joined a new community. There were few, if any, careers for us to enter and for many of us nursing was a good option. We might not have had a 'Florrie' (Florence Nightingale) call (vocation) but we cared enough to want to help people. It was such fun and when someone had had a tough time the empathy and the closeness of the others brought us together. We used to

> complain about the old battle-axes who were in charge of the wards. Wow, some of them were truly frightening when they got angry. But you know the care that our patients got was superb. I can't remember many bedsores at all. My husband got a bedsore after being in ICU for three days. SHOCKING. I did not meet many caring nurses while he was in hospital. Mmmmm…. I have thought a lot about the caring that we did as nurses. The support that we gave each other was then given to our patients. If we did not know how to care when we went nursing, we learnt it first with each other. The other thing is that with the long Nightingale wards we were on view all the time and there was no place to hide. We had patient contact all the time. We sure worked hard…no need to ever have a sleeping tablet…we just dropped into bed and slept. BUT …I don't think that any patient was ever not cared 'for' or is it 'about'. There were always enough of us to go around. If one nurse did not get on with a patient there was always another nurse who did. So no one was ever left out of that caring equation.

The rain stopped and we went our separate ways.

'…no one was ever left out of that caring equation.'

The words rang in my ears and mind and an understanding of an important part of nursing history. We had nursed at the same time in different countries and experienced the same insight into a short period of recent history. It was only short – I cannot put a time frame on the period – the 1950's and 60's. The period spanned the time in which antibiotics could only be given intramuscularly and there was no shortage of nurses or money to pay them.

Although the attrition was high, student nurses, for the most part, loved nursing. In spite of the long hours and the fact that it was a six-day week, they belonged to a supportive community in the nurses' home. Appreciative patients stayed long enough so they became real people and the trajectory of the illness could be followed. We were not taught how to *Care*. There was an assumption that student nurses had their patients' welfare (interest) at heart, there would be *Care*. If we did not know how to *Care* there were the role models of the senior student nurses and the Sisters. The revered, all powerful, all seeing, knowledgeable Sister reigned supreme and no one ever dared cross her path or give nursing care that was not of the

highest standard. Every patient was not only well cared for, they were Cared about – it was true *Care*. It was, I posited, the *Golden Age of Care*

I wondered if it was this *Care* that gave rise to the academic interest in a new *Care*, a *Care* that was not a vocational Caring. I wondered if it was this *Care* that had been the genesis of the interest in trying to quantify a special kind of Caring that is unique to nursing. Except I counter, it is a *Care* that is unique to a specific period of nursing, the Golden Age of *Care* coinciding with the Therapeutic Revolution and governments' economic ability to employ student nurses to adequately staff large teaching hospitals with committed Sisters whose wards were their domain and the care and Caring developed into *Care*.

The Present: a perspective on factors influencing *Care*

A modern Industrial Revolution

The current climate of nursing practice in which this research takes place is in a state of evolution. It can be likened to the industrial revolution in that the changes are as dramatic and will continue to influence ordinary people's lives for decades to come. The changes that began with the Therapeutic Revolution have accelerated. The Therapeutic Revolution has, if anything, quickened, spurred on by the Technological Revolution. The advent and introduction of technology has been hailed as one of the most significant advances in the management of disease. Heart-lung machines, haemodialysis therapy and an amazing array of 'X-ray' technology continue to be refined and used, sometimes with what seems to be reckless abandon. Ultrasound during pregnancy, a useful diagnostic tool, is now being used to give parents the first 'photo' of their baby or, as a midwife colleague recently commented, to help determine the colour scheme of the baby's bedroom.

In spite of scientific advances in curing disease, many regard the current health care scene with pessimism. The health care system is one that is constantly in a state of flux, even as the new technologies change, new diseases such as Sudden Acute Respiratory Syndrome appear. The economic climate keeps adjusting to government and insurance changes. Technology has not, however, been the panacea that it was hoped it would be, and has in itself generated problems such as its cost. Inequities in availability and unforeseen complications in the use of the technology have led to further costs and ethical conundrums. In addition to the constant options

that are available to patients, there are the concomitant factors of cost (political bargaining) and nurse education (changed and still changing) that impinge on the multiple relationships in the health care sector. These relationships and the changing climate encroach on the patient and the family leaving them wondering if anyone is interested in them. It has been suggested that the focus on technology has replaced the focus on the patient (Baume, 1998; Heskins, 1997; Kelly, 2004; Larkins, 1998).

There are also differences and problems associated with nurse education. The move to tertiary education was for the most part applauded in Australia. This move generated its own problems. These included the fact that the theory-practice gap widened, the hospital and the schools of nursing were no longer in close proximity, and the practicum was/is seen as being too short. Nurses do not practise in isolation and the ramifications of the total health care system impinge on nursing practice.

The RN practising in this changing and challenging contemporary health care scene are under pressure. The question about how the RN can enact *Care* needs to be done with an understanding of the current climate in which the RN practises. This climate will be explored under the three inter-related areas of technology, the milieu of care and the importance of the dollar. While these are in many aspects separate issues the overlap is significant and thus the divide is an artificial one. This is not an analysis of these constructs, it is simply a perspective on the current environment in which nurses practise and patients are ‘cured’.

The impact of Technology

In 1975, Dr Chris Barnard performed the first heart transplant. The patient lived only five days. The post Therapeutic Revolution had become passé and doctors, it seems, were looking for new frontiers to conquer. A heart-lung machine had been developed to keep the patient alive while heart surgery was being performed, and it remained for someone brave or eccentric enough to take a heart out of a living person, throw it away, and insert a new heart into the living patient from someone else who had recently died. The patient was nursed in a special unit and Chris Barnard and the patient became the centre of intense media coverage around the world. The media coverage in South Africa was voluminous and Barnard was portrayed as a national hero. The patient died after five days but a new technological age was born. While there are differing opinions about the precise beginning of the

technological age, the heart transplant was one of the beginnings. Just 10 years later, Califano (1986) notes that "We are so inundated with the miracles of modem medicine that we tend to forget how far along this century was before a patient who visited a doctor had a better than fifty-fifty chance of being helped" (p 75).

Although the focus is on technology, the technology itself cannot be considered in isolation. Specialised Intensive Care Units became standard in all city hospitals to accommodate the high-technology machinery used to keep patients either alive or stable until they were well enough to maintain their own systems. The technology in those units needed expert nurses and doctors to give the necessary competent care and the patient was often 'lost' in a sea of tubes and cables. Califano's (1986) is cynical in his descriptions of hospitals as being "gleaming temples of hope ... stocked with some of the highest of high-tec equipment" (p. 96) and doctors as being, the "powerful high priests of the health care industry" (p. 68).

The new (expensive) technology often requires new custom-designed buildings and specially trained staff to operate. This results in escalating operating costs. The investment of millions of dollars in buildings is expected to bring in high returns. The 'life support machines' such as the heart-lung and dialysis technology and the new X-ray scanners are well known and attract the attention of the media and a curious public. Kemp (1997) refers to the 'false market' that uses "visual marketing" to promote the further use of the technology, including even the contents of the humble medicine chest in every home that houses the latest in thermometers (digital, no 1onger mercury), bandages and headache capsules (p. 17).

Sax's comment on the patients' expectations that "no result would be unattainable" (p. 226) is as pervasive in 2004 as it was in 1984. Bates and Lapsley rightly regard these expectations as being unrealistic, and that the realities of sickness care are different. The technologies are complex and often involve tedious and uncomfortable preparation. Factors such as emergencies in the departments, malfunction of complicated machinery and lack of privacy lead to depersonalisation and depression due to high expectations not being met (Bates & Lapsley, 1985). Often it is the nurse who is in the centre of such scenarios. They are left to console patients about the interminable waiting and give apologies to frustrated relatives about the seemingly mismanagement of their loved ones. It is difficult to *Care* in an environment like this and the abilities of even the most *Care* RN are often stretched.

While the above is referenced from literature that is twenty years old, it still reflects the pervading sense of expectation that is prevalent in society today. The press and public opinion mirror this. Expectations are high for immediate cures, the latest that technology can offer, well as personalised attention. The 'new' patient believes that the health care system is 'free' and that access to health care is immediate and easy. Healthcare cards assist in the payment of medications and 'pay' the doctor (provided the doctor bulk bills). In Australia the concept of waiting lists for surgery or Out Patient specialist care is considered to be mismanagement and an intensely political issue. The 'new' patient and/or family are also (often) more 'informed', via the Internet and libraries, about the disease from which the patient is suffering.

Kemp (1997), in discussing the development of new technologies, is careful to point out that the case is sometimes made that the patient "is encouraged to feel better in direct ratio to the expense of the equipment used", or the number of specialists to whom they are referred (p. 17). This belief is further enhanced by stories of acquaintances, friends of friends and a media obsessed with stories of survival as a result of the marvels of modern medicine. These new patients forget that their parents (or grandparents) in the mid nineteenth century, "went to hospital to die or because there was no-one to care for them at home. ... It was rarely curative. At worst, and quite frequently, it was deadly" (Califano, 1986, p. 96).

The Technology in its broadest sense includes the pharmaceutical industry, insurance companies and biotechnology and equipment companies who are less visible and are there for profit. These 'profitable acolytes' do not have the same sense of professionalism and/or philanthropy (in its widest sense) as the medical profession and their cost effectiveness and ethical and safety issues should, according to Califano, be scrutinised (Califano, 1986). Is Australia immune to such statements? In May 2003 the Pan Company had its manufacturing licence suspended. A newspaper interview with an employee tells of hurried and inefficient cleaning of machines between the manufacture of different white pills. Proper cleaning slowed production and reduced the profit for the owners. (The Australian May 1 2003 and April 30 2003).

The Therapeutic Revolution was firmly entrenched by the end of the 1970s. In the mid 1980's an interviewer on Television was told by a National Health Service doctor that prescribing pills was a way in which the consultation could be cut short.

"It's a nice way of getting rid of the patient, you scribble something out and rip the thing off the pad. The ripping off is really the "Fuck off" (Porter, 1997, p. 686). The current climate is no better, as there is a recurring theme about poly pharmacy and the indiscriminate prescription of drugs. The public, for the most part, seems to accept this as the 'cure-all' for their problems. Caring, as personified by the interest of the Nineteenth Century doctor, has largely disappeared but the magic of medication remains. The expectations of a *Care* nurse in the mind of the public is still strong and although the quantitative research does not reflect this, the qualitative research does (Gardner et al., 2001; Irurita, 1999; Schmidt, 2003).

The impact of technology on health care has not diminished, although the size of much of the technology is being significantly reduced. Students in undergraduate nursing programs view these areas as being the sine qua non of nursing and vie for clinical placements in the areas of high technology (Rushworth & Happell, 2000; Wilson, 2004). It is in itself testament to the fact that *Care* is not always a motivating force in career selection (While, 1998). In a qualitative study to determine the reasons for choosing nursing, Boughn found that the desire for power and an ability to use power was an important aspect in the choice to enter nursing. The construct itself was discussed but not the specific areas that the participants wanted to work in (Boughn, 1999). It is possible to theorise that the power that nurses have in high technology areas such as intensive care is a reason for wanting to nurse in these units.

The Milieu of *Care*

The hospitals of the Twentieth Century, with the long 'Nightingale wards' of twenty or more patients, who were under the 'eagle eye' of experienced, often highly-skilled specialist sisters and student nurses, have vanished. The 'gleaming temples of hope' (Califano, 1986) have individual rooms (why are they still called wards?) that are for the most part quiet, and painted in pastel colours. They have soothing piped music (the choice is the patients') and a menu to choose from (depending on the patients' condition) catering for most tastes. The ensuite means that even hygiene needs are met within the privacy of patient's own room. Some patients prefer the privacy, while some do not.

However, RN complain that the patients are sicker, and as they cannot see other patients, a mindset of being the only patient prevails, making increasing

demands on the nurse. The workload remains at an approximation of six patients per RN but hidden factors such as distance and demand will sometimes more than double the workload. *Care*, in the changing clinical climate, is difficult.

Half a century ago, the word Caring would have been an acceptable word to describe the health care system, particularly when describing nurses. An attempt to find a single adjective to describe the current influences on nursing practice is unproblematic. The word is 'changing'. Care is dominated by a 'bio-medical paradigm' in 1986 (Centre, 1988) and is no different in 2005. The bio-medical paradigm continues unabated as the search for a cure is replaced by a search for immortality.

It is an axiom that 'doctors cure and nurses care'. In spite of this, Bauman et al (1998) argue that the care/cure dichotomy is an ongoing debate and that health care should be a continuum, with a blurring of the roles of the health care team. Webb (1998) suggests that there should be an integrated model of caring in which all three participants (nurse, doctor and patient) have an equal role. Nurses, doctors, together with patients (in their suffering) are in fact a triad and pivot around the central premise of *Care* as they come to terms with the disease (in its broadest definition) and the effects that it has on each of their lives. This is then a model that incorporates the patient as well and in so doing rejects the simplistic dualistic notion of cure-care (Webb, 1998). Webb (1998) cites Nightingale as admonishing nurses to be obedient to doctors and yet Nightingale also says that medicine and nursing need to work together, a fact which is often overlooked (Baly, 1997).

Sax (1983) does refer to the nursing workforce as being important. In a discussion on aged care and the mentally disable, he notes that there are 'particular' difficulties in finding trained staff who were energetic. This is a curious statement that he does not justify. One is left to wonder just what he might have said in 2005. The average age of the RN in the workforce is 45 (Heath, 2002, pp. 50-51). While a RN of 45 still has a tremendous amount to offer in terms of skills and experience, the pace and stress of a busy understaffed unit is scarcely an ideal environment in which to work or mentor new graduates. Nurses who were energetic some 20 years ago are scarcely as energetic in 2005. There is also the additional stress of striving to hold on to values such as giving quality care and *Care* to the patients. While these comments could be interpreted as being ageist, this issue is of concern and was addressed in the Nursing Review (2002) under the heading 'Changing nursing

worker profile'. The problems that are of concern are the ageing workforce and the trend towards working shorter hours. The recommendation was made that State and Territory Governments establish workforce forums to address the issues (Heath, 2002, p. 18).

The relationships of doctors and patients have also changed dramatically. Some thirty years ago, patients' local GP was the first contact families had with the health care system. Doctors knew their patients and nurses knew the doctors. Referrals were seldom made; as the availability and range of specialists was far less that it is today (Centre, 1988). The number and range of specialists has increased dramatically, to the extent that patients are sometimes 'under' two or more specialists and even the assertive patient is left wondering what is going on with 'their' body.

Califano, writing specifically about the USA, and Bates and Lapsley, targeting the Australian health care system, are cynical about the power that doctors wield in the health care system (Bates & Lapsley, 1985; Califano, 1986). Bates and Lapsley (1985), both sociologists, devote an entire chapter to the medical profession, with the first section being a cynical discussion on the power that the medical profession holds in the health care system. Phrases such as "doctors give orders which other people obey", "doctors prefer to use expensive hospitals rather than build up community services", and in spite of newer professions seeking registration they have "maintained a closed shop" (Bates & Lapsley, 1985, p. 201). Of professions in general it is suggested that they are "often seen as greedy, self-interested, and not concerned with the public welfare" (Bates & Lapsley, 1985, p. 211). Nursing is not mentioned in spite of the fact that nurses, then and now, form the largest group of health care professionals.

In spite of the advances which have been made in the health/sickness care, it would seem that the doctors (and one is forced to ask the question about nurses as well) are becoming worse at relating to people as they seek to effect a cure. The family doctor and his relationship to the entire family with a position of trust is no longer a factor in the day-to-day management of health (Baume, 1998; Brooks, 1998; Ellard, 1998).

The psychological needs of the patient, it would seem, are secondary to the curing focus of medicine. In a philosophical discussion, Baumann et al (1998) allege that curing by the expert (the doctor) is episodic, outcome focussed with goals that are measurable and is often dramatic but is almost always expensive. From the

patient's perspective the description of being "dehumanised, objectified, negatively stereotyped, disempowered and devalued" (Coyle & Williams, 2000, p. 1238) is hardly complimentary of the health care system. The patient is often secondary to the doctor's absorption in the cure. An indictment on the medical profession, that is both sad and frightening, by a leading Australian doctor notes that,

> It is harder and harder to find a modern practitioner interested in patients as people. Many citizens are bitter about the failure of their own medical attendants to communicate empathetically or effectively or equally (that is, as one person talking to another) at times which are the most significant and most emotionally charged in their lives (Baume, 1998, p. 200).

The RN is caught up in this triad of relationships. As they seek to promote a holistic model of car, they find that ordered care from different doctors makes for fragmented care. The patient is no longer the patient, submissive, grateful, unquestioning, 'patient' patient of the pre-therapeutic revolution era. Instead the patient has become the 'new patient', or as Flanagan (1997) calls him/her, 'the customer'. The customer is more knowledgeable, discerning, and assertive and has higher expectations of an instant cure and quality care, and that there has been a "significant shift in the patient's power" (p. 14). It could well be that some of the older RN find this shift difficult to cope with. The quiescent patient has become the questioning patient and could be perceived as a threat to the RN power and knowledge. Parker (1999), in a discussion of the 'new' patient and the increasing consumerism of health-care, takes a different perspective saying, "in a commercial approach to service delivery" there is often little time left for the "intangible, deeply personal and profoundly significant professional-recipient relationship, which involves dimensions of comforting and caring" (p. 21). The question is then posed as to how the nursing relationship can be sustained in a commercial climate. In terms of accountability, Parker suggests that the notion of customer reflects a financial relationship while the nursing relationship is one of responsibility (Parker, 1999).

In addition to this, the system of nurse education is still in a state of flux. Although the first nursing students to be accepted into a tertiary education program in Australia were in 1977, the final transfer of nurse education into universities in

Queensland took place a mere twelve years ago. The 'new' RN is still regarded with suspicion. The clinical skills of the new RN are often considered as being 'poor' and the criticism that the new graduate is too theoretical and un-*Care* is not uncommon. Current nursing education programs have units dedicated to *Care* constructs and have *Care* philosophies imbedded in nursing department mission statements.

The new graduate (particularly in Queensland, the last state in Australia to move to tertiary based nurse education) enters a workforce that still has much of the culture of previous generations of hospital trained RN. It is a complex situation where the workforce is ageing, nursing research is meagre and economic cost cutting is endemic. In an effort to restart the debate on workplace reform, Cowin and Jacobssen argue amongst other issues, that there are significant "ideological" differences between nurses (Cowin & Jacobsson, 2003). In addition, the milieu is one that is time-poor. RN do not, as Parker suggests above, develop any significant professional-recipient relationship (Parker, 1999). While these ideological and organisational differences are significant, it is important to remember that the organisational side is largely driven by monetary considerations.

Recent research indicates that there is little improvement. In a discussion on the nursing shortages being experienced at this time, Wickett, McCutcheon, and Long (2004) cite the concomitant issues of "burnout and stress", "patients with increasing levels of acuity, shorter lengths of stay", and nurses "dissatisfaction with standards of care" as well as horizontal violence (p. 344). The issues of the shortages within the RN workforce and the incidence of horizontal violence impact on the way *Care* is learned, as well as on the *Care* care that patients receive.

The nursing shortage has resulted in the substantial use of contracts and part-time RN with some wards operating on double or triple the normal number of RN on the rosters with their working weeks ranging from 16-34 hours. (Heath, 2002) There are factors here that impact on the student and the graduate nurse. The part-time RN either does not (always) have job security, and as a result could conceivably not *Care*, or on the other hand, as some RN simply do not want to work full-time, there may be no commitment to the hospital or nursing, and hence do not bother to *Care* or practice *Care*. The chances of the student (or the patient) getting to know an RN are slim indeed. Both these factors are important in the delivery of *Care*, immediate for the patient and patient satisfaction, and long term for students as they 'learn' *Care* through the positive/negative role modelling of the RN. The Australian study of

patients who were in hospital for longer than two weeks, found that patients became reluctant to ask for help when they did not know the RN. The patient satisfaction was low, as the turn-over of staff was rapid and patients in many instances did not get to relate to the RN (Irurita, 1999).

Furthermore, the high rate of horizontal violence in the workplace is also problematic. In a study of workplace violence in Queensland the researchers found that there was a high percentage of violence from patients towards nurses, and although the percentage was less from nurse to nurse, it occurred. This large, random sample of nurses from the Queensland Nurses Union had a response rate of 53%, with a total of 1477 surveys received and collated. The conclusion notes that it is an area of concern and that although there are policies in place to deal with the problem; further work is needed to address the problem (Hegney, Plank, & Parker, 2003). While the problem of workplace violence and the impact it has on the student nurse and the inexperienced RN is not discussed, the importance it has on the *Care* factor cannot be underestimated.

In this climate the new GRN has little time to observe and learn important *Care* enactments or strategies from the more experienced RN.

The importance of the Dollar

Cheap student nurse labour of 50 years ago has disappeared. The health care system had relied for centuries on a willing, dedicated (mainly female) workforce. In the case of the religious orders, the labour was 'unpaid'. The Technological Revolution and the sociological changes, such as the feminist movement, as well as the transfer to university education for nurses, have changed the cost structure of the health care system. The problems of increasing costs within the Australian health care system were apparent even in 1986,

> The government is facing an uphill battle just trying to pay for existing services, leaving aside the constant cry of medical research and new technological developments for extra resources (Centre, 1988, p. 14).

Califano, Sax, Bates and Lapsley and the Health Issues Centre published important works on the contemporary health care scene in the mid 1980's. All four publications are important as they give a critical appraisal of the health care scene as it then was, and twenty years later the issues, exacerbated, remain the same.

Although the Califano perspective is from the USA, the issues that are addressed are similar to the ones that were (and are) being faced in Australia, and the rest of Western society (Bates & Lapsley, 1985; Califano, 1986; Centre, 1988; Sax, 1984).

The titles of the above publications are in themselves interesting, in that they give a snapshot of health care at that time. The Australian publication is sub-titled, *Politics and Policies in Australian Health Services* - but the thrust (and sting) is in the title itself - *A Strife of Interests* (Sax, 1984). On the other hand Califano's subtitle, *Who lives? Who dies? Who pays?* is startling, suggesting that there may be an ethical aspect to the book. There is not. It is an aggressive attack on the economics of the health care system in the USA and some possible solutions (Califano, 1986). 'What's wrong with the health care system?' indicates that there are problems that exist and need to be solved (Centre, 1988). The cryptic title *The Health Machine* is a critical analysis of the impact of the new technology in health care, and says that the lack of understanding of technology has resulted in a system that has lost the 'human face' (Bates & Lapsley, 1985). Lewis (1997) in a discussion on the politics and medicine indicates that,

> Since the 1980's, the issue of spiralling costs and the question mark hanging over the relationship between the provision of medical services and health status has resulted in doubts about the efficacy of scientific medicine and about the role of the State in making it more widely available (p. 287).

In the 1980's and 1990's Government had attacked the issue of spiralling costs by attempting to reduce the power of the medical profession. Although Lewis is referring to the health care system in the UK, she indicates that the problems are the same in Northern Europe and North America (Lewis, 1997).

These fiscal problems are the same in Australia and are reflected in the writings of Sax, Wynn and others (Centre, 1988; Sax, 1984; Wynne & Armstrong, 2003). The way the money is proportioned is a complex issue, and is the most important factor in the analysis of the problems and the dissatisfaction within the health care system, some twenty years ago and at the present.

Sax's (1984) 'strife of interests' focuses on the history of 'medical benefits'. How money for the health care system is obtained; from the government, insurance payments or by the patient form the basis of the text. The mindset of the public then,

and now, is that medical care should be free, provided by the government. In conclusion, there is a cynical comment that "Continuing change and conflict seem to be inevitable" (Sax, 1984, p. 236). The comment has proved true. Debate in Parliament regarding allocation of resources continues. Concluding a discussion on the present state of Medicare and the proposed changes, Wynne and Armstrong (2003) note, "What is clear is that the current Medicare battle is likely to be as fierce, as bitter and as acrimonious as that of 40 years ago" (p. 12).

An analysis of the health care system in 1988 identified a number of consequences that could occur if the problems within the system were not addressed. Medical research and services were claiming an ever-increasing share of the GDP and the cost of the system had grown to 'astronomical proportions'. Increasing specialisation had led to the medicalisation of normal pregnancies and the overuse of pharmaceuticals and diagnostic tests. The result was an increased cost to the consumer, deskilling of GPs and more importantly, the lack of an integrated approach (Centre, 1988). A prediction was made that some of the consequences of the then present system would lead to such problems as lengthening of waiting lists for elective surgery and outpatient appointments, increasing demands between specialities/technologies for the dollar, increased direct cost for the consumer, increased industrial militancy, the problem of chronicity and dealing with the results of patients saved by modern technology and left with residual complaints (Centre, 1988).

Many of these predictions have eventuated. Waiting lists have lengthened; specialities are attracting even more money; patients are paying more; nurses' strikes (almost unheard of in the past) have occurred, and the fragmentation in health care is a greater problem now than it was in the mid 1980's. The questions posed in 'What's wrong with the health care system?' and the problems of increasing cost remain. The problems in the health care system have in fact exacerbated, leaving the consumers (patients and family) angry and the current climate is reflected in the chronic shortage of RN in an ageing workforce (Heath, 2002, pp. 50-51).

Superimposed onto this scenario have been the introduction of university education for nurses and the loss of cheap labour in hospitals. While the nursing profession has in general welcomed this move, there have been fiscal problems here too. The cost of monitoring clinical practicum for students has proved much more costly than originally predicted. A workforce with higher educational qualifications

becomes costlier to the health care system itself and, as predicted in the UK, "fewer practitioners will be employed as they become more expensive" (Woodward, 1997, p. 1002). It is also happening in Australia (Cowin & Jacobsson, 2003; Heath, 2002). The cost to students, who traditionally have been paid while learning, has proved to be a disincentive to taking up nursing as a career. Learning how to *Care* from a respected role model is lessened, as the dollar drives the patient turnover to generate higher and higher profits. Cost effectiveness of care and *Care* in the 80's was a problem, continued into the 90's as evidenced by the International Council of Nurses using it as a theme for International Nurses Day in 1993 (Buchan, 1992) and continues to be problematical. The 'financial distortions' of care in the health care system continue (Baume, 1998).

It is little different in the USA. Mohr, Deatrick, Richmond, and Mahon (2001) are scathing of nurses and the health care system in the USA. They are critical of the values that nurses hold in what they call 'turbulent times'.

> As teachers and clinicians, we shared a concern about the emergence of an overarching profit orientation in both health care delivery and academic settings. We observed the turbulence resulting from the need to adapt...Our clinician colleagues throughout the United States were being made to take on more and more responsibility for more and more patients. Staff cuts and layoffs were becoming a daily occurrence. Under similar pressure to be more productive, our academic colleagues throughout the United States found themselves vying for a pot of federal research dollars amid increasingly intense competition in a research environment that was demanding more for less. Teaching loads were creeping ever upward and support for teaching was slithering downward (Mohr, Deatrick, Richmond, & Mahon, 2001, p. 30).

Values have, they contend, become lost in the 'pursuit for profit', although there is an apparent general agreement on the common core values that are held in nursing (Mohr et al., 2001). It is of note that the article was published some eight months before 9/11, the World Trade Centre disaster. If the times could be called 'turbulent' prior to this event, it is difficult to envisage what the present 'times' might be called.

The concepts of 'who dies and who pays' remains, and the 'strife of interests' has increased. The question of economic rationalism is one that is of increasing

importance. The significance is that the health care dollar is not infinite; the overall costs of technology and running cost of hospitals are increasing to the extent that decisions have to be made as to who gets how much money.

The Caring literature

Difficult choices

While a description of *Care* is 'elusive', an excursion into an understanding of Caring from a multi-paradigmatic view is necessary. Perspectives on Caring differ in different disciplines, as does the literature on *Care* differ across nursing specialities. The *Care* in midwifery is not the same as the *Care* in palliative care. However the phenomenon, Caring, remains at heart, the same. It became essential to explore (however briefly) what the non-nursing literature had to say about Caring.

The extent of the literature on Caring is vast, my reading was extensive, and the final choice was made on how particular writers shed light on Caring. The discussion on Caring is essential but will of necessity be brief.

Caring in the humanities, religion and philosophy, revealed common threads that, although they were different in themselves, blended with each other to give a better understanding of Caring. By themselves they were often delicate, tenuous perhaps in the single application, but, woven together, the threads or concepts strengthened and became useful in a broad analysis of what Caring means in day-to-day living. The analogy/metaphor of a three-fold cord created by a blending of these concepts is a useful way in which to describe and understand Caring multi-paradigmatically. Although I wanted to keep the discussion focussed on the other disciplines, it was necessary to link nursing into the discussions at times.

Philosophers, Mayeroff and Lewis, are contemporary and widely known. Mayeroff's treatise *On Caring* is quoted in the *Care* literature, often superficially, I found, and so he is included to give some of his lesser-known interpretations. Lewis, the second contemporary philosopher, is included as his perspective is distinctly Protestant and there was a need to add a modern theological aspect to balance the historical vocational aspect of nursing. Both Campbell, also a theologian, and who is quoted in some of the nursing literature, and Nouwen (priest, academic and psychologist and chosen for his perspective after working with the handicapped) were chosen for their interpretations from a Christian perspective. Peck

(psychotherapist) and Goleman (psychologist) together with Carl Rogers, were considered to be of importance, as they contribute some interesting practical perspectives in their interpretations of Caring.

Mayeroff – Philosopher

The importance of Mayeroff cannot be underestimated, as his work on Caring is considered by some to be seminal. Mayeroff only wrote one book, *On Caring*, and it is this book that is widely quoted in the *Care* literature (Mayeroff, 1971).

The interpretation of Mayeroff's Caring is superficial in the nursing literature. The central tenet of Caring, being the facilitation of growth in the other, is omitted or misinterpreted. It is his eight 'ingredients' of Caring that are quoted. Some give the concepts in detail (Blattner, 1981) while others simply list all or some of the 'ingredients'. These ingredients, Knowing, Alternating Rhythms, Patience, Honesty, Trust, Humility, Hope and Courage occupy a brief thirteen pages of text. The rest of the book is devoted to an exposition of the multifacetedness of Caring, the meaning of life, and the importance of self and the other in the process of Caring.

The Caring process, which he describes, is one that is multifaceted and an integral part of life, ordered by Caring. As a philosopher, exploring the meaning of life, his view is best described by quoting from the summing up of his philosophy in his own words.

> Through finding and helping to develop my appropriate others, I discover and create the meaning of my life. And in caring for my appropriate others, in being in-place, I live the meaning of my life. This meaning is not felt to be external to my life and tacked onto it; there are a rightness and necessity about it that are rooted in my being: the meaning is acknowledged to be my own (Mayeroff, 1971, p. 62).

'Appropriate others', refers to the encounters in the continuing sequences of life, where people are open to 'finding' the 'other' in need of Caring. Mayeroff does not differentiate between family members or clients/patients or even the general public giving examples of the 'other' in a wide variety of situations ranging from psychotherapists and their clients to concert pianists' audiences and the parent-child relationship. Caring is dealt with as a holistic concept. There is no division between

the physical, social, spiritual or psychological and Caring is depicted as central to life itself including the complexities of ordinary living.

There are two central interconnected concepts to Mayeroff's (1971) philosophy. The first is that the core of Caring is contained in the words 'to develop' or to help the other to grow and develop an independence and the second is that within this growth of the other is there is a growth in the giver. There is reciprocity in Caring.

Lewis – Philosopher and Writer

C. S. Lewis (1898-1963) an Oxford scholar and philosopher, wrote *The Four Loves*, an interpretation of human relationships and love. There is a distinct Christian philosophy in his writing but this does not make it any less relevant to a fuller understanding of Caring. The proposition is made that Love is an essential part of being, and there are two loves that are part of the innate nature of man. Beginning from birth as helpless beings there is an innate need for love (care and Caring) manifested as a Need-love, from others, on physical, emotional and intellectual levels. The other love is Gift-love. Gift-love is love that is given without the need for love to be returned and is likened to parental love, although spiritual health is dependent on the level of Gift-love that is given to God (Lewis, 1998).

Lewis (1998) then postulates that there are indeed four kinds of love within the paradox of Need-love/Gift-love which he calls, Affection, Friendship, Eros and Charity. Affection, is the 'least discriminating' (p. 31) of the loves and is a love that is described as "warm comfortableness" and is the love that gives and takes in an easy relationship between likely and unlikely people. The second love is that of Friendship and is woven into the matrix of Companionship, but cannot be called companionship, as it is more diverse and committed than companionship. Friendship is a love that 'shares a common vision', is a meeting of 'kindred souls', and will eventually blossom into an 'Appreciative-love'. Eros is described as a love that is enduring, self-effacing and transcendent, between a man and a woman and includes sexual love (Lewis, 1998, pp. 67-68).

The final love, Charity, is a love that is God given or Divine Gift-love. Gift-love loves that which is not lovable and is the giving of the self or the ability to serve the stranger in need of care and love. It is this love that is closest to the *Care* that is described by some of the nursing writers. Although the concept of a vocation is not

mentioned at all, there is, in the final discussion, an underlying message that it is the presence of God within that motivates and calls to a life of service to others (Lewis, 1998, p. 122). The vocation here is a spiritual vocation similar to that of a vocation to the priesthood or to missionary service.

The four loves are in and of themselves unique but cannot be in reality separated. The loves flow from one to the other and in doing so becomes a whole, intrinsically necessary, according to Lewis, to the happiness and fulfilment of humanity. *Care*, cannot be Charity or Affection as defined by Lewis, for it would then only be a part of the whole and lose its uniqueness. The warm comfortableness of Affection cannot be likened to *Care* as the professional relationship discounts the essence of the Affection described by Lewis.

The difference between *Care* and Caring is something that I have not been able to find in the *Care* literature. *Care* is as it were only connected to Caring by a superficial analogy made by the writers, and the two can never be coupled. The word, coupled, has been used after careful deliberation. Coupled is in essence a conjoining (a Siamese twin) of two similar but different entities. *Care* is not a spiritual concept.

Campbell – Theologian

Alistair Campbell presented the 1983 Edward Cadbury lecture series at the University of Birmingham, on what he called, "a notable phenomenon of contemporary life, the rise of professionalism in caring"(Campbell, 1984, p. vii). This is interesting in itself as it is some five years prior to the inclusion of caring in the CINAHL index. Nursing, medicine and social work are proposed as being the Caring professions as they are the only ones who are closely involved with "people who are in an especially vulnerable situation" (Campbell, 1984, p. 1). Campbell agrees that there are in fact other professions that deal with people who are vulnerable, such as the police, teachers, or even funeral directors, but he argues that they work within much clearer defined boundaries. There is no discussion on boundaries.

Campbell (1984) interprets Caring from a theological perspective and his short definition of Caring as 'moderated love' is contained within the title of the book- *Moderated Love - A Theology of Professional Care.* There is no further

definition other than a slightly 'longer' definition that Caring is 'consistent, skilled informed concern'. Caring, he asserts, is a love that is an *agape* love, which is a love of humankind and a resistance to 'illness, pain and social disadvantage'. The love is, however, balanced by the professional attitude of the carer, and is a love which is 'moderated'. This 'moderated love' is described as being unlike the sometimes 'erratic' love of family and friends. In an interesting analogy, moderation is likened to a moderate climate, where the professional has 'a hard-headedness and consistency in the care' with a balance of 'reason and emotion.' (Campbell, 1984, p. 85). Briefly, hidden in this discourse, is the phrase "reaching out to another in the desire to enhance the value which is seen" (Campbell, 1984, p. 85). This is the essence of Mayeroff's 'to develop'.

Campbell (1984) argues that the image of the doctor as 'god' and the nurse as 'ministering angel' is in fact detrimental to the professional relationship of nurse/doctor and patient as it intimates a power relationship (p. 125). The outworking of a moderated love, is best summed up by using Campbell's (1984) words. He suggests that "...a moderator is to be *prevented* by your position *from taking sides*" (p. 126) as he argues that the carer needs to be able to maintain a "critical distance". This is not easy as "too great a distance prevents the helper from responding to the others need: too little distance disables the helper …" (p. 81), as in this case they are not able to be objective. In spite of the distance the notion of "agape" - the love which risks self in order to enhance value" (p. 82) still continues to function. The knowledge of the professional is used to have "an understanding which links knowledge with love and suffering" (p 89) and thus related to the aspect of a "covenant" (p. 104).

Campbell (1984) argues that the medical position is frequently one of power that is largely a factor of knowledge, and that this power is sometimes intensified by the patient in the form of an idolatrous relationship, in the hope that the doctor will be able to cure the disease. Thus the Caring relationship puts the curing ability of the doctor in jeopardy and the patient would be at risk of not being cured. The doctor is in a privileged position and "so close to human vulnerability and finitude, that however modest and well-intentioned its practitioners, an aura of special influence tends to surround them" (Campbell, 1984, p. 32). Campbell proposes that it is the 'godlikeness' that produces a dependence that in the final analysis prevents the patient from being compliant. It is then that the nursing profession is able to "fully

promote" self-reliance in the patient. It is at this juncture that the discourse turns to nursing.

The nurse is likened to a skilled companion who gives of their expertise, only required for a specific time, after which the patient is no longer a patient and is able to continue the journey to full health. Although this is a simplistic interpretation of the role of the nurse, the delicate balance of companionship and professional detachment in which skilled care is given is in fact a 'form of love' (Campbell, 1984). The companionship is "a personal involvement and a giving to the other that transcends skill or technique" (Campbell, 1984, p. 51). The references to love as a form of *Care* are few and the context of this love is always dealt with in relation to the religious aspect of vocation and the way in which nursing is in fact a spiritual response to a call of God. Inherent in that call is a love for the human race. Campbell does not deal with concept of vocation in detail but does say that although the idea of a vocation has become outmoded, the fact that there is more to nursing (as well as medicine and social work) than money or status and that there should still be an element of vocation in the choice of such careers (Campbell, 1984).

A quantitative research project into factors in course selection of 314 non-metropolitan prospective nursing and teaching students included a question about the timing of career choice. The results indicated that only 31% had always wanted to nurse while in education almost half (46%) had always wanted to teach (Robertson, 1989). This trend was reflected in a similar study in the UK ten years later, where it was found that there were no clear reasons for career choice (While, 1998). Although there is an element of vocation indicated by an inherent desire to nurse, the meaning of the concept as a call from God is no longer applicable to the choice of nursing or for that matter to any other secular career. Power, and a sense of gratitude from the patient, have been cited in recent research as other reasons for taking up nursing as a career (Boughn, 1999; Rognstad, Nortvedt, & Assland, 2004).

Nouwen – Priest, Theologian and Psychologist

Henri Nouwen (1932- 1996), was a lecturer (Yale and Harvard Universities), Catholic priest, author of over twenty books, and carer to the handicapped at L'Arche for many years. He relates how his attitude to others changed and how he himself discovered a sense of peace and tranquillity he had not known before as he

participated in the care of the handicapped. The contributions that each individual makes to the humanity should be the sole vocation of living and be done gracefully and carefully, as life is a cycle of living and dying. It is from this point that he elaborates on his philosophy of what Care really is.

> What does it mean to care? ... The word *care* finds its roots in the gothic Kara which means lament. The basic meaning of care is to grieve, to experience sorrow, to cry out with. I am very much struck by this background of the word care because we tend to look at Caring as an attitude of the strong towards the weak of the powerful toward the powerless of the haves toward the have-nots and in fact we feel quite uncomfortable with an invitation into someone's pain before doing something about it (Nouwen, 1989, p. 129).

Although Nouwen's interpretation of Caring is not included in the discourse on *Care*, there are two aspects regarding Caring in this instance that need to be noted. In the first he addresses the power relationship. Nurses too are in a powerful position, and the patient is aware of this and takes care not to upset the nurse. Research into patient satisfaction (and this would include the research into the patient's perceptions of the Caring nurse) indicates that an inherent limitation in the research because of the patient's reluctance to be honest, fearful of poor treatment in future admissions (Coyle & Williams, 2000; Hyrkas & Paunomnen, 2000; Hyrkas, Paunonen, & Laippala, 2000, Reynolds, Scott, & Jessiman, 1999).

The second aspect is diametrically opposed to the above concept. In the intrinsic desire to care, there is also an implicit imperative to actually *do something.* For nurses it is not enough to enter "into someone's pain", whether it is emotional or physical the inherent (and taught) impulse is to give the 'Pethidine' or to counsel as the patient tells the painful story. Nurses are taught to 'do'.

Amongst a multitude of specialities, such as social and mental development, team building, sports psychology and treating psychoses, psychology deals with emotions and relationships. An excursion into psychology seemed to be imperative. The psychology literature is rich in dealing with relationships between the therapist and the client. Rogers, gives a simple technique/approach on how to show Caring and thus by extension, how *Care* can be shown.

Rogers – Psychologist

The excursion proved to be useful. Carl Rogers' (1967) own definition of his notion of 'unconditional positive regard' as being 'I care' provided not only another facet to the interpretation of Caring- it also encapsulated in three words how to show Caring professionally. The concept of Carl Rogers 'unconditional positive regard' is a recurring theme in the humanistic psychology. Rogers, in his personal account of how he developed client-centered therapy (Rogerian psychotherapy) tells how he came to a realisation that those in need can only be helped by providing a relationship so that the person could discover an inner capacity for personal growth through the therapeutic relationship established between the counsellor and themselves.

There are, Rogers postulated, three distinct parts to the therapeutic relationship: genuineness, acceptance and a "deep empathetic understanding which enables me to see his private world through his eyes" and it is in the process that the therapist (or nurse) becomes a "companion" (Rogers, 1967, p. 34). Campbell (1984) uses the same analogy of 'companion' to describe the therapeutic or Caring relationship and the concept of growth is central to Mayeroff's philosophy of Caring (Mayeroff, 1971). Rogers argues forcefully that the helping relationship cannot be created mechanically by using a set of predetermined criteria, as this would "destroy the personal qualities" that research has been found to be essential to good therapy (Rogers, 1967, p. 50). This is in direct contrast to Goleman, (1999) who maintains that the 'empathy' can be learned. Rogers (1967) also makes the point that there is an attitude or behaviour which the budding psychotherapist is urged to cultivate, and as an extension to this is in fact something that can be 'learned'. Rogers called this, 'unconditional positive regard' and is the way in which the therapist creates a Caring climate. It is in the context of this discussion that Rogers gives his definition of unconditional positive regard as being simply "I care". The words that Rogers uses in the discussion are "acceptance", "caring for the client as a separate person" and "no conditions of worth attached" (Rogers, 1967, p. 283).

Travelbee and Watson focus on the relationship being an essential aspect of the *Care*. The term 'relationship' is never explored. Rogers is probably referring to an extended relationship in therapy while Travelbee wrote in the era of the longer hospital stay of 10 days, whereas Watson refers to the relationship as being in the

moment (Dreary, 2002; Travelbee, 1977; Watson, 2000a, 2000b; Watson & Smith, 2002). While the word 'moment' is never defined, the interpretation that I have taken is the fact that the RN is able to 'connect' with the patient and in so doing the patient feels *Care* for.

Rogers deals briefly with the concept of the therapist's own psychological maturity as, "the degree to which I can create relationships which facilitate the growth of others as separate persons is a measure of the growth I have achieved in myself" (Rogers, 1967, p. 56). Rogers does not elaborate on this definition nor does he give any measure for it. Some thirty years later, Goleman defines emotional intelligence as being psychological maturity, exactly what it seems Rogers is referring to in the above (Goleman, 1999).

Scott Peck – Psychotherapist

Scott Peck's two books, *The Road Less Travelled*, subtitled *A new psychology of love, traditional values and spiritual growth* (1988), (the catalyst for reading the book) and *The Different Drum* (1990) could conceivably be called 'pop psychology' (Scott Peck, 1988, 1990). Scott Peck is however a psychotherapist of standing and his books on personal and spiritual development and community have been through a number of editions and reprints. His inclusion is brief but his discussion on love must not be overlooked, and the concept of 'soft boundaries' was significant.

Scott Peck, in the introduction to love, and prior to giving his definition, maintains "Love is too large, too deep ever to be truly understood or measured or limited within the framework of words." He says that he is very conscious that in trying to describe or define love that he is playing with a 'mystery' and trying to "examine the unexaminable and to know the unknowable". Despite this assertion, love is defined, as "The will to extend one's self for the purpose of nurturing one's own or another's spiritual growth" (Scott Peck, 1988, p. 81). He attests to the fact that the definition was arrived at through clinical observation but is, in addition, a process that is circular, includes self-love, requires effort (courage to move forward) and is an act of will necessitating commitment. First published in 1978, the notion of growth is similar to the philosophy espoused six years earlier by Mayeroff (1971). (There are no references in the book to Mayeroff.)

It is in *The Different Drum* (1990), a book that focuses on community, that the concept of 'soft boundaries' is briefly discussed. Scott Peck tells of the time he

spent at a Quaker school. Boundaries in most organisations are necessary and schools are not exempt from this necessity. However, in the Quaker school the boundaries were 'soft' and although teachers and their authority were respected, the pupils were never afraid of them. The atmosphere was one in which 'individualism flourished' and in an atmosphere in which all were 'friends'. For the first time in his life, Peck felt that he was "utterly free to be me" (Scott Peck, 1990, p. 31).

Boundaries – a discussion

Campbell also deals with the importance of boundaries, in the Caring professions. Boundaries, Campbell argues, need to have a "balance of reason and emotion" and the "hard-headedness and consistency" which exist in all professions - indeed they must in order to maintain the neutral, unbiased relationship of the professional and the client (Campbell, 1984, p. 85). The boundaries in the nursing profession exist for a number of reasons, including assisting the patient to cope with the personal intimate situation and the challenges of the disease process and the resulting treatments. Indeed, nurses in the past have been warned 'not to get involved' with patients (there are numbers of RN trained under the hospital system who still remember, and implement, this dictum) and yet recently the emphasis in the *Care* literature has been repeatedly interpreted as a relationship (Watson, 1999).

There is a dichotomy here. *Care*, being relationship driven versus not being involved. Lawler, in discussing the body in nursing, found that the neophyte needed strategies to cope with the intimacy of nursing. One of the suggested strategies is to maintain a professional stance (Lawler, 1991). As soon as this is assumed, there is the strong argument that Caring is replaced by what could be interpreted as a non-Caring professional attitude. There is clearly a need for boundaries. If there is to be *Care*, how are boundaries to be interpreted? Scott Peck describes 'soft' boundaries (Scott Peck, 1990). 'Soft boundaries' is a simple concept and one that could possibly be easily taught.

The neophyte Nurse is urged to remember that they are professionals. What does a professional mean? Visits to the doctor (the medical professional that the student is most likely to be acquainted with) are often hurried and impersonal. The boundaries are often impregnable. Scott Peck's notion of 'soft boundaries' adequately describes what the relationship should be (Scott Peck, 1990). However, students are not aware of many boundaries. Doctors and lawyers command respect

and boundaries are accepted as part of *their* professions. Teachers at high school, neighbours and some relatives, and then academics at university, are all generally known on first name terms, and the casualness of these encounters are transferred to the hospital and the relationships with the patients.

There is no need to return to the etiquette of the middle of last century. However it is of note that in an important qualitative/quantitative *Care* research conducted in Canberra a patient adds to her comments… '*Please do not call me Sweetie'* (Gardner et al., 2001). (Emphasis mine)

Salovey and Mayer – psychologists

The concept of emotional intelligence, as defined by Mayer and Salovey is rarely discussed in the literature on *Care*. It is a concept that should be of importance in a profession that professes Caring.

In the 1990 seminal work of Salovey and Meyer (Salovey & Meyer, 1998 reprint of article) they propose that there is a "a set of conceptually related mental processes involving emotional information" (Salovey & Meyer, 1998, p. 314). The concept was new and termed 'emotional intelligence'. Five years later Goleman published his work *Emotional Intelligence,* acknowledging that the title was taken from the work of Salovey and Meyer (Goleman, 1996).

Mayer and Salovey (1997) revised their definition of emotional intelligence seven years after their seminal work was published. This definition is given in full.

> Emotional intelligence involves the ability to perceive accurately, appraise, and express emotion; the ability to access and/or generate feelings when they facilitate thought; the ability to understand emotion and emotional knowledge; and the ability to regulate emotions to promote emotional and intellectual growth (Mayer & Salovey, 1997, p. 5).

In a later publication, Mayer (2001) indicates that there are two emotional intelligences in the literature – the scientific approach which he and Salovey brought to the attention of the discipline (psychology) and the 'popular emotional intelligence' that facilitates life achievement and is readily achieved. The scientific approach is still not fully understood, although two tests have been developed to measure emotional intelligence. The relation of emotional intelligence to other

intelligences and research on the impact these have on the daily lives of people is still to be done. (Mayer, 2001) What is important here is the allusion to the fact that there is an aspect of emotional intelligence that can be learned.

Goleman uses the word Emotional Intelligence in the titles of two of his texts *Working with Emotional Intelligence* and *Emotional Intelligence – Why it can matter more than IQ* but uses the term Emotional Competence (EC) in text and deals with the components as being essential and important concepts in organisational performance and effectiveness (Goleman, 1996, 1999). Goleman and others are the writers of what Mayer labels 'popular emotional intelligence' (Mayer, 2001). Research showed "IQ takes second position to emotional intelligence in determining outstanding job performance" (Goleman, 1999, p. 5) and that the concepts of EC play an important part in successful companies. Goleman indicates that EC is not new and that having EC enables the person to recognise emotions in others and oneself and that the simple definition is psychological maturity. Over time, this psychological maturity has come under a variety of names, from "character" and "personality" to "soft skills" and Goleman notes that excellence and pleasure in work are one and the same thing as "loving work" and that "to reach the top rung, people must love what they do and find pleasure in doing it" (p. 106).

The question of what love in nursing is, was addressed by a group of RN in a Socratic Dialogue, in which they found that love in nursing is something that is beyond *Care*. The question of what the extra element was, possibly love in nursing, could not be answered. Implicit in the discussion was the fact that in essence the group loved their work (Fitzgerald & van Hooft, 2000). While this may be perceived to be different from the premise stated by Goleman, it is of interest here as the findings were that in the love of nursing there is a "commitment of the nurse to want the good of the other before the self." (Fitzgerald & van Hooft, 2000, p. 482) This is of course the Mayeroff/Lewis interpretation of love/Caring.

While Goleman (1996; 1999) treats the concept of emotional competence in a business context (there are only two references to health care), the importance of empathy and commitment in his emotional competence framework cannot be disregarded. Goleman developed the Emotional Competence Framework, divided into two areas of what he terms 'capabilities', Personal Competence and Social Competence. Personal Competence is further divided into three areas, Self-Awareness, Self-Regulation and Motivation. The Motivation group includes the

construct of Commitment, defined as being able to align oneself with the goals or mission of the organisation. Commitment in nursing is sometimes viewed as being only of historical interest so it is noteworthy that this is included here.

Social Competence is defined as the way in which individuals handle relationships and is divided into two areas called Social Skills and Empathy. One of the abilities in the Social Skills component, Adeptness at inducing desirable responses in others, includes the competency to communicate (listen effectively and 'sending convincing messages') and to be able to initiate change. The importance of empowering patients to change their health behaviour patterns is seen as fundamental in nursing. The Empathy component includes the abilities to understand others, being able to sense the developmental needs of others, as well as a 'service' orientation in meeting the customer's needs (Goleman, 1999, p. 26-27). Later, in a discussion on Empathy and what it is, Goleman asserts that it is an awareness of others' feelings, needs and concerns, and that the essence is the ability to "sense what others feel without their saying so" (p. 135).

All the research figures are related to business, and areas such as nursing, where patients would by inference be greatly affected by emotional competence, are not discussed. The importance of emotional competence to this research is the assertion by Goleman and others that emotional competence is not fixed genetically and can be developed. (Goleman, 1999; Wood & Tolley, 2003) There is criticism that it is premature at this stage of the development of the emotional intelligence research to think that emotional intelligence can be taught. (Mayer & Salovey, 1997) It is not the intent in this review to differentiate between emotional intelligence per se and having emotional competencies. Goleman sets the tone of his book in the opening sentences,

> The rules for work are changing. We're being judged by a new yardstick: not by just how smart we are, or by our training and expertise, but also by how well we handle ourselves and each other (Goleman, 1999, p. 3).

While Goleman has written this predominantly for the business sector, the fact that health care has become a massive industry, together with the primary importance of nursing, means that the notion of emotional competence in nursing is incontrovertible.

John Heron whose interpretation of participative inquiry underpins this research has also written in the area of counselling. His text on *Helping the Client* (1990) gives some interesting insights into the discussion on emotional competence. The three-chapter introduction is a general guide to helping the client, first published in 1975 it includes the concept of 'emotional competence'. Heron describes three levels of emotional competence that are pertinent to this discussion on the topic. At the first level the helping relationship is influenced and restricted by the emotions of the helper; at the second level the helper's emotions do not get in the way or the helper is not aware of their emotions getting in the way of establishing a helping relationship. At the third level the helper is aware of their emotions and should their emotions surface and get in the way of the helping relationship, there is an ability to recognise that this is happening and there is an ability to take steps to control/correct their emotions, and it is this level of emotional competence that can be learned though group work and co-counselling (Heron, 1990).

A search for literature on the concept of emotional intelligence in nursing proved difficult. Work on 'relational capacity' and the development of an Interpersonal Competence Instrument do not mention the writers on emotional intelligence (Hartrick, 1997, 1999; Ravert & Williams, 1997). The early seminal writings on emotional intelligence began in 1990 and Heron's three levels of emotional competence were republished in 1990 so it is disheartening that nurse academics have not moved outside the writings of the nursing profession.

Hartrick writes about 'relational capacity', a concept that seemed to be closely related to emotional intelligence. The capacities, however, are a response to the 'other' and while the capacities are important and are a move away from a mechanistic behaviourist model, the concepts are academically phrased and do little to add an understanding of the concept for undergraduate students (Hartrick, 1997). In a later publication, Hartrick uses the phrase 'intricacies of relational practice' in the abstract but does not deal with the concept in detail in the body of the article (Hartrick, 1999). In neither article are the concepts of emotional intelligence or competence addressed.

What is important is the concept that if Social Competence and the emotional competency of Empathy can be facilitated, then it is emboldened on nursing to research (and teach/research) the concept. Of note however is the importance of clinical/field education in the facilitation of the ability to *Care* through experience

and learning through watching. Inherent in this is the increasing maturity of nursing students as they are exposed to the clinical milieu.

The nursing research clearly indicates that this growth in *Care* ability is facilitated by participating in small groups and role models. It is these two factors that Heron indicates as being necessary for the development/growth of emotional competence and counselling abilities. Role-modelling is, Heron says, through co-counselling.

Severinsson research of student views of their supervised clinical practicum indicated that they had grown personally in addition to the acquisition of specific nursing knowledge. This growth was evidenced in their personal growth in areas of sensitivity, assertiveness, responsibility and an increased ability to listen. Their self-confidence, reflective abilities and development of insight were also increased (Severinsson, 1998). The careful clinical supervision and reflection on the experience is a factor in the development of emotional competence, however it is interpreted, and further study on the concept is required.

I finally found a reference to Goleman in an editorial, where Janis Bellack notes the work of Goleman and challenges the nursing profession to stop 'tinkering' with curricula and address the important area of emotional intelligence. The importance of educators themselves and their role modelling of emotional intelligence, prior to its inclusion in the curriculum, is stressed (Bellach, 1999). In addition to the fact that nurse educators have a responsibility to students and their future employers, there is also a responsibility to ensure that graduates, in order to give the public care and *Care*, "acquire the personal and social skills associated with emotional intelligence and thus are able to use their cognitive knowledge and technical expertise to full benefit" (Bellach, 1999, p. 4).

The *Care* literature

The modern foundation of *Care*

Florence Nightingale is depicted as the founder of modern nursing: the epitome of dedication to nursing (the profession) and Caring (the soldier/patient) and who asserted that she had a call from God and that this sense of vocation was evident until shortly before her death in 1910 (Baly, 1997; Donahue, 1985). It is a view of Nightingale that is not held by all writers. This view is what Chiarella calls the

'ministering angel' concept. She argues that it is an outsider story that was actively fostered by Florence Nightingale and that it is a concept that is deep within the psyche of the public (Chiarella, 2002, p. 39). It is not only the public. Indeed there are some within the nursing profession that hold this concept as well. Watson urges the nursing profession to return to the vision of Florence Nightingale, as her "vision and wisdom ring(s) true and speak(s) to us still" (Watson, 1999, p. 261).

An investigation by the Victorian Government in 1918 revealed that nurses' work included general cleaning as well as patient care and that they received less pay than well-paid servants. It noted that 'The hospital system was dependent on the sacrificial model of nursing,' in which the good nurses were kind and unquestioning. (Minchin, undated) It is this essence of kindness, together with the religious command to Care and care, a vocation, that has laid the foundation for the intense interest in *Care*. The interest in the concept is also, as I have suggested, rooted in the recent, short-lived phenomenon – The Golden Age of Caring.

It was not until 1988 that the word 'caring' was included in the CINAHL Thesaurus, as previous to this, research and scholarly writing on the subject was included under the words, empathy, interpersonal relations, nurse-patient relationships, nursing care/psychosocial factors, nursing staff, and hospital/psychosocial factors. The word 'caring' had to be included as the volume of research on the subject had increased exponentially. An indication on the unabated interest in the topic is shown by a simple database search on CINAHL for the period 1998-2000 (31 months) on 'caring in nursing' which produced 6481 responses.

It is difficult to pinpoint a single seminal author on *Care*. Travelbee, Blattner and Watson are three of the early authors on *Care*, although the first two are relatively unknown.

Travelbee's interpretation of *Care* is not explicit although Caring is implicit throughout the book. I suggest that Travelbee was possibly the first exponent of *Care* but simply did not use the politically correct words or was hesitant to use Caring. Blattner's book 'shows the practising nurse how to apply the notions of humanistic caring' notes Selye in the foreword, and indeed the book, although entitled *Holistic Nursing*, is mainly about *Care* (Blattner, 1981). A search of the literature to find how many times she is mentioned, revealed that Blattner herself has published few articles and done no research on *Care*.

Watson published early and has continued through to the present (Watson, 1985, 1989a, 1989b, 1998, 1999, 2000, 2005; Watson & Smith, 2002). Jean Watson, Distinguished Professor of Nursing, and Founder, Centre for Human Caring, Endowed Chair in Caring Science at the University of Colorado, is considered the principle exponent of *Care*. Watson's extensive writings span a period of some twenty years and many of the articles on *Care* quote from her writings. Watson struck a cord in the nursing profession and the notion of *Care* began to be taken seriously and the exponential increase in research referred to above occurred. Travelbee, Blattner and Watson will be reviewed in more detail.

Travelbee – The Therapeutic Relationship

Travelbee (1926-1973) wrote two books: one on psychiatric nursing and the other on compassion in nursing, possibly precipitated by the fact that she felt there was a lack of compassion in Catholic charity institutions (Hobble, Lansinger, & Magers, 1989). Travelbee's book on Caring was published in 1966. This book had two editions and the second edition was reprinted eight times with the eighth printing in 1977, four years after her death and just two years prior to the publication of Watson's seminal text. Travelbee's small (by today's standards) book *Interpersonal Aspects of Nursing* appears on superficial reading to be about communication, nursing, and the suffering patient. The central theme is the necessity for therapeutic relationships in nursing but it is essentially about Caring. Caring is only defined once in the introduction, although Travelbee discusses the essence of a Caring relationship throughout the text. The Caring factor is explored within the concepts of suffering, sympathy and empathy, and rapport. An analysis of the references (given in footnote form) indicates that there was little in the way of research and critical discourse on *Care* when the book was written. There is a selected bibliography (updated in 1971) that is not extensive and here again there is little of consequence in relation to *Care* and Caring. References from psychology predominate and there is also a smattering of references from medical journals amongst the paucity of nursing literature.

It is the Introduction that carries the most important message for the student nurse, although it appears as not being part of the text itself. The discussion is brief and simple, and is quite clear that nurses can learn how to establish a therapeutic relationship. Firstly, there is a need to have a body of knowledge and secondly the ability to use that knowledge. Without knowledge, the nurse is unable to use a

"disciplined intellectual approach to problems", and there is also a need to "possess a profound understanding of the human condition" in order to learn to use oneself in a therapeutic relationship (Travelbee, 1977, p. 1).

The discussion on suffering (and pain) is lengthy and philosophical and focuses on the individual with no distinction between the nurse and the patient. One can only Care if there is something or someone that is going to be lost, and to truly Care there must be suffering. In the summing up of suffering there is no doubt that it is the patient who is suffering and the nurse who is the one who Cares. It takes 'courage to care' since it is in the exposure to Caring that there is the chance of being hurt by the "objects of his care" (Travelbee, 1977, p. 65). Mayeroff's (1971) eight ingredients of Caring include 'courage' and C. S. Lewis (1998) discusses the same thought in his Four Loves indicating that, "To love at all is to be vulnerable" (p. 116). Travelbee and Lewis both posit that there can be no love (Caring) unless there is a love that is given first, and in the giving the giver is enriched and the cycle is constantly renewed. 'Relationships' that could still be forged with the sometimes long hospital stays of 1966 (first publication date) are a factor of that era. Travelbee (1977) continues her introduction by referring to the fact that it is her belief that "dehumanising tactics are being practised increasingly" and that the trend is not "abating" (p 2). It is an interesting observation and clearly has not ceased, as this research later indicates.

This is in contrast to a recent study where student nurses' motivation to help others was explored. Although altruism was a strong motivating factor, the desire for acknowledgement and positive feedback was equally strong. This wish for positive feedback and acknowledgement from patients who are sometimes seriously ill is problematical, as it reflects an ambiguity in the helping motive (Rognstad et al., 2004).

Travelbee has an interesting discourse on the differences between sympathy and empathy and believes that in nursing both are needed, as empathy is a precursor to sympathy. "Authenticity" enables the nurse to demonstrate sympathy by giving emotional support together with the correct nursing actions that will alleviate the patient's distress. Thus to have true sympathy in nursing, an emotional and a physical nurturing is required. The use of the word authentic is very focused and purposeful as Travelbee goes on to say that it cannot be 'feigned or pretended' and that 'one possesses it or not' (Travelbee, 1977, p. 143). There is thus a subliminal

message that caring is inherited. This is evident in some of the phrases such as "the ability to truly care for and about others - to translate the quality of caring into action in nursing situations - is the core of rapport" (p. 155).

Relatedness and rapport are used as synonyms and are defined as being a process in which the patient and the nurse interact and find common ground in a mutual relationship. It is of interest that in the discussion on rapport, the nurse's ability to be aware of and value the human-ness of the patient, is only achieved by an ability to 'be' as well as 'do' - the central themes of Watson's early work (Watson, 1985). This awareness leading to a rapport with the patient is further briefly described as an 'openness to experience' that will often be a moment of 'relatedness' and that such moments are indeed 'but moments' and that there is no need to verbalise the experience. Describing and defining the moment is not easy and yet it is succinctly described as being "permeated by a type of ambient, enveloping, all pervasive quietness and understanding of each to the other" (Travelbee, 1977, p. 153). It clarified for me Watson's notion of the caring moment in her later work. Rapport is "mutually significant" and the nurse and the patient become "involved - each to the extent of his capacity for commitment" (Travelbee, 1977, p. 151).

The 'capacity for commitment' **from** the patient is open to question in the current climate of shorter hospital stays and higher levels of patient acuity. The shorter stay does not allow the time to develop a commitment and the patient is often too sick (or unconscious) to have the capacity for developing a commitment. Further, the use of the word 'involved' is interesting, as for many decades student nurses were specifically taught not to get involved (Lawler, 1991). Involvement is discussed by Travelbee, who contends that it is not a problem, as the professional can and will become involved but will not be 'incapacitated' by the involvement (Travelbee, 1977, p. 146). Subsequent to her writing this, the notions of Scott Peck's 'soft boundaries' and Campbell's 'critical distance' appeared and are indeed a more practical way of viewing a professional relationship (Campbell, 1984; Scott Peck, 1990).

The number of reprints of Travelbee's book is an indication of its usefulness, probably in pre-registration programs. It is a matter of conjecture what impact this made on the *Care* that patients were conscious of receiving and whether it is some of this generation of RN who have contributed to the *Care* literature. The concept of altruism is strong in Travelbee's work, and whatever aspects of *Care* that can be

taught, altruism is not one of them. I reflected on this, and wondered if I was being pessimistic and decided that altruism could not be taught.

Blattner – Holistic *Care*

Barbara Blattner's *Holistic Nursing* was published in 1981, just two years after Watson's first text on *Care*. Her book is interesting for a number of reasons. In the first place, the front cover declares that it is a text on holistic nursing and that the reader is provided with self-assessment tools to enable the reader to give holistic nursing. This is in itself an unusual approach as the focus in most nursing texts is on the patient and not the nurse. In the second place, Hans Selye, has written the foreword and concludes with "*Holistic Nursing* shows the practising nurse how to apply the notion of humanistic caring". (Blattner, 1981, p. vii) Humanistic caring is not reflected in the title. Holistic nursing was an important part of nursing curricula in the late 1970's and through the 1980's prior to being supplanted by the *Care* models. Blattner, in the opening sentences of the Preface, writes that she is proposing a conceptual model of holistic nursing so that it can be taught and practised. It is a model that defines "holistic nursing as the conscious application of the life processes of self responsibility, caring, human development … to help clients help themselves move toward high-level wellness" (Blattner, 1981, p. viii).

This definition explains the Selye emphasis on *Care* as well as the focus on *Care* throughout the text. The chapter on *Care* (Blattner, 1981) is developed around four concepts. Caring is first explicated using Maslow and Mayeroff, the exposition on Caring by Mayeroff being one of the most complete in the many texts and research literature on Caring that I have been able to find. Mayeroff's eight 'ingredients' of Caring are succinctly explained, without the essence of their meaning being lost. The focus of the second concept is that of caring for the self or Intrapersonal Caring, followed by the third which deals with Interpersonal Caring. Finally, the concept of community Caring is dealt with (Blattner, 1981).

A central premise is that the nurses must learn to know themselves. There are a number of exercises and suggestions on how this can be done. Nutritional health, exercise and stress level questionnaires have been adapted to suit what was probably the average nursing student of the time (Blattner, 1981). This self-knowledge is an important factor in Goleman's exploration of emotional competence.

Watson – the *Care* moment

Jean Watson is without doubt the most prolific of the *Care* authors. There are 13 pages listing her publications on the Caring Science/Theory of Human Caring on her web-site. http://www.uchsc.edu/nursing/caring. Watson ascribes her emphasis on interpersonal qualities in *Care* to Rogerian theories. (Bennett, Porter, & Sloan, 1989) She founded the Centre for Human Caring at the University of Colorado Health Sciences Centre in 1986.

In her first book, *Nursing: The philosophy and science of Caring,* first published in 1979 Watson proposed that there were 'ten carative' factors that were essential to the understanding of the science of *Care* (Watson, 1985). The intention/focus of the carative factors was to incorporate them into the nursing curricula of undergraduate students. The focus of the text is to generate understanding of foundational aspects of nursing that underpin *Care* (Watson, 1985). Indeed a number of undergraduate courses have used these factors as the philosophical framework for undergraduate nursing curricula.

The carative factors include factors such as the formation of a humanistic-altruistic system of values, the instillation of faith-hope, the cultivation of sensitivity to one's self and to others, gratification of human needs and the allowance for existential /phenomenological forces (Watson, 1985, p. 8-9). What is particularly important is that Watson uses the phrase 'science of caring' repeatedly, meaning the science of the carative factors. It is a multi-concept notion of *Care* and not simply a single concept of compassion, or any of the many other synonyms that are used to denote Caring.

This list is well known and often quoted. What is probably less well known is the application that Watson (1985) gives to each carative factor. An example is nutrition, one of the requirements in the gratification of human needs. It is dealt with succinctly. Without going into any detail such a food groups, balanced diets and needs across the life span, the 13 pages covering the need for food and fluid is a remarkable sine qua non of nutrition. An ability to synthesize material from the sciences (and Watson is emphatic that these are necessary) and apply these principles to the area of nutrition means that the necessity for long explanations about food and the patient are unnecessary. (Supplementary texts would be needed.)

Ten years later, Watson moves into the philosophical arena and asserts that "human caring (is) one of the central missions for the profession" (Watson, 1989, p.

41). Twenty years on from the publication of her first text, Watson's definition of *Care* in *Postmodern Nursing and Beyond*, is lengthy, although it is also perhaps both an explanation of her evolving philosophy of *Care* and an insight as to how it is developed in the book.

> Caring in nursing conveys body physical acts, but embraces the mind-body-spirit as it reclaims the embodied spirit as the focus of its attention. It suggests a methodology, through both art and aesthetics, of *being* as well as *knowing* and *doing*. It concerns itself with the art of being human. It calls forth from the practitioner an authentic presencing of being in the caring moment, carrying an intentional Caring-healing consciousness. It concerns itself with the transpersonal and trans-cultural, and with the objective, subjective and the intersubjective. There is openness to another possibility of being in the world, with caring and healing as a ontology within an expanding cosmology (Watson, 1999, p. 10).

The importance of the transpersonal, and the necessity for transformation of the self that goes beyond time and space, and the link to the spiritual is emphasised. A careful reading of the *Philosophy and Science of Caring* (1985) reveals an evocative theme of the importance of personal growth in the carer. *Postmodern Nursing (1999)* is, in effect, a continuing of the concepts that were begun in *Philosophy and Science of Caring* and importantly the earlier concepts are as valid today as when they were first written, although the nomenclature and some of the interpretation has become more philosophical. Watson (1999) describes a paradigm shift, to the Transpersonal caring healing model belonging to Era III/Paradigm III. The caring moment is a complex phenomenon involving intentionality in which the carer and the cared for metaphysically merge in a moment that is beyond time and space. It is as it were a spiritual meeting that brings together the past and the present creating harmony and healing (Watson, 1999, pp. 115-119).

The language that Watson uses is forceful and for some challenging. In her earlier work there is an injunction that self-development is an obligation (Watson, 1985) and later this is changed to the concept that there is a moral commitment to the developing of the self (Watson, 1999). It is difficult to say which is the more forceful although the earlier notion of an obligation is perhaps better understood.

The combination of the science - it seems that science is used in a very general sense - and 'art' of nursing that is not used specifically is an interesting one. Watson's latest book is simply called *Caring Science as Sacred Science* (2005). It is specifically for the postgraduate student and those interested in the *Care* paradigm. Watson gives three new 'considerations' for the framing of a Caring-Science model, the first of which is of interest to this research.

> Developing knowledge of caring cannot be assumed; it is a philosophical-ethical-epistemic endeavor that requires ongoing explication and development of theory, philosophy, and ethics, along with diverse methods of caring inquiry that inform caring healing practices (and knowledge) (Watson, 2005, p. 29).

I reflected, that if Watson at *this* stage of her publications still believes that 'caring cannot be assumed', then, my research seems a drop in the ocean of *Care* knowledge – but that it ***is*** part of an 'ongoing explication and development' and 'epistemic endeavor' to elicit knowledge about *Care*.

The undergraduate student is not likely to read Watson's books, at least at our university, and so it is left to the lecturer to interpret and teach these fundamental issues of obligation and a spiritual journey if the Watson interpretation is being followed. This brings a dimension to the teaching of *Care* that for some less experienced lecturers may become problematical or indeed difficult. Teaching *Care* is a challenge for the nursing profession as much now as when Madeline Leininger wrote the Foreword to Watson's first text more than twenty five years ago (Watson, 1985).

Watson has further developed the notion of intentionality and a caring healing consciousness in an article that moves the constructs into the realm of noetic science. It is a complex area of philosophical debate that will not be dealt with here. What is important is the conception that within the model of Intentional Transpersonal Caring-Healing there is a process by which "individuals maintain their ability to cultivate and manifest deep values, beliefs, and meaningfulness in the midst of suffering and disease." It is the notion of being able to "cultivate" and "maintain" that is important here. In the event of a nurse not being caring, one is able to cultivate *Care*, and the Caring nurse is able to maintain a *Care* attitude. It is an

interesting assumption and indicates that Watson is *not* too heavenly minded. In conclusion, a set of exemplar exercises is given to assist the nurse in cultivating an intentional caring consciousness and practice (Watson, 2002, pp. 5-6). It is these eight intentions that bring a reality to the profound discussion on *Care* in the Twenty-first Century.

Watson and Foster (2003) indicate the way in which Watson's theory has a distinct practical application. Models of *Care* using Watson's philosophy and concepts are still being generated and implemented in the health care system. The Attending Nurse Caring Model® suggests a structural approach to implementing *Care*. A pilot project is described in which an Attending Caring Nurse (ACN) is responsible for co-ordinating and assisting in planning *Care* healing practices in a paediatric unit. The ACN structures and facilitates theory to be translated into practice eventuating in a transformation of "conventional approaches, while activating and renewing nursing caring paradigm" (Watson & Foster, 2003, p. 364). The *Attending Nurse Caring Model*® is an example of the influence that Watson has had and is still having on nursing theory and clinical practice. While a single sentence does not do justice to the ideology of the concept, a problem remains on how systems like this could be implemented nationwide in the USA (or Australia). Without the guidance of an ACN how would many thousands of individual RN enact *Care*? Enacting *Care* must be individually driven. The question remains as to how the special kind of Caring that is *Care* is enacted followed by the question as to how this *Care* can be passed on to future generations of RN.

The following discussion uses the concept of *Care* as it is interpreted in this thesis, but uses a lower case cee in order to be consistent with Jean Watson's writing. Watson (2003) notes, that love and caring are central to the shared humanity of nurse and patient and the ethic of the nurse being and becoming. The concept of the Caring Moment, espoused in previous work, is continued and likened to a radiating field of cosmic love. The philosophical debate is profound and thought provoking as some of the concepts of Levinas and Logstrup are woven into the discussion. In spite of the challenging concepts, Watson ends by summarising the reasons for the theoretical notion of transpersonal caring, as being able to make a difference, the transformative power of caring, the circularity of caring, and the spirit energy of thought and choice. Also summarized are the practices of caring, which give clarity to the concepts of caring that have been discussed on a theoretical level. These

"practicalities" of caring are not new, and include listening, being non-judgmental and honouring each person (Watson, 2003).

'Other' *Care* literature

The sheer volume (already referred to) of the 'other' *Care* literature precludes a thorough review in this research, and to take a position on a particular interpretation is imprudent. At the same time, an examination of the *Care* literature cannot be simply left to the review of the selected early *Care* writers. The bibliography on what has been read is large and wide-ranging, but the selection of authors has been limited to what is directly relevant to this research. There is no real consensus in the *Care* literature and perhaps that is why the writing and research on *Care* continues unabated.

Margaret Dunlop was among the first Australians to comment on the academic debate on *Care* and her article, *Is a science of caring possible?* (Dunlop, 1986) is still quoted. Caring in the generic sense is differentiated from Caring in nursing by hyphenating the two words, 'nursing-caring', a strategy used in this research by indicating 'nursing-caring' as *Care*. Dunlop (1986) argues strongly that a science *of Care* is not possible because science operationalises items (or behaviours) and therefore, can be measured or counted, while *Care* cannot be counted. The factors that indicate *Care* could, she argues, perhaps be subjected to scientific scrutiny (and then it would be a science *for* caring) but then the factors would be just that, simply factors and not concepts which are 'highly dependent on context' and therefore not science. Watson and Leininger are critiqued for giving lists of caring factors that "operationalise nursing-caring". Nursing-caring, she argues, is always context driven (Dunlop, 1986, p. 37). Benner (2004) takes a different perspective, in a discussion on the relational ethics of comfort, touch, and solace and comments that there is a "fallacy that what can't be counted, doesn't count" and that the ordered and charted therapies are often considered more important than *Care*, as the interventions can be counted (Benner, 2004, p. 349).

Almost twenty years after Dunlop's (1986) article on the science of caring, Curry (1995), also Australian, in a chapter on what appears to be *Care*, uses the word, 'humanities' in the title. Attitudes are discussed at length and it is interesting to note not only the variety but also the different 'designations' that are given to the same attitude. Caring is the most obvious and in spite of some clear definitions to

the contrary, caring is designated as being love through to a therapeutic relationship. Curry (1995) then gives a comprehensive list of fifteen characteristics that are 'central' to what he calls clinical relationships and appears to be careful not to specifically becoming involved in the *Care* debate. Healing, nurture, support, comfort, care, encouragement, awareness, wholeness, acceptance, dignity, integration, education, enabling, protection and liberation are given. There is an important addendum to the list as he says that the relationships need to be practised with patience, rigour, gentleness, alertness, attentiveness, observance, creativity, generosity, compassion, responsibility, integrity, trustworthiness, astuteness, balanced judgement, humility and simplicity (Curry, 1995, p. 223). The chapter deals with the humanities, scholarly wisdom and research and concludes in a simple and straightforward manner in the observation that nursing is head, hand and heart (Curry, 1995). The obfuscation was apparent in the lists and the lack of any clear conclusion. The list that Curry gives encompasses the qualities of Caring and the way in which *Care* should be practised, indicating the complexity of *Care*. If Curry is defining *Care*, and there is no reason to suppose that he is not, then it follows that students who enter nursing course/programs will already have some/many of these characteristics/values even if they are embryonic. The list encompasses values/attitudes that are inherent characteristics that most people are expected to have by the time they enter university. It then follows that these values/attitudes need not be taught, and one need only to teach *Care* (Curry, 1995). In spite of this, it is obvious that we do not live in a perfect world and that all nurses should have all these characteristics is unrealistic.

The work of Paley has already been referred to and his rejection of the way in which *Care* has been simplistically and repetitively dealt with (Paley, 2001, 2002). In a response to Paley and his critiques on caring research, Dreary et al (2002) note in their abstract that "multiple perspectives enrich understanding of phenomena and often confirm previous perceptions" (p. 96) and that in fact "Paley has done special violence to quantitative analyses of caring" (Dreary, 2002, p. 100). These arguments range across a number of journal issues and are taken up and referred to by other recent writers. Although *Care* as evidenced by the incidents in this research is recognisable (and therefore open to some quantitative research) the incidents are in themselves unique, and thus the mystery of *Care* will never be uncovered –

quantitatively or qualitatively. This having been said, the mystery of *Care* continues to be explored and like fire, if it is discovered, can and will change the world.

McCance, McKenna, and Boore (1999) in a comparison of four Caring theories, conceptualised by Watson, Leininger, Roach and Boykin & Schoenhofer indicate that the origins of these theories fall into four categories, anthropology, human science and metaphysics, philosophy and theology, and philosophy and human science. In spite of the different origins the commonality of the theories is that the care of the patient is primary and the importance of the nurse-patient relationship. They conclude however, with the notion that, as *Care* is so important, it then becomes essential for nurses to understand the ideas in the theories (McCance, McKenna, & Boore, 1999). I would strongly counter that, nurses do not need to understand these theories in order to enact *Care*.

In a study that addressed the conceptualisations and theories of *Care*, Morse, Borttorff, Neader, and Solberg reviewed the literature prior to 1990. In an analysis of 35 authors' conceptualisations of *Care*, they elicited five perspectives on the nature of *Care*. These perspectives were, caring as a human trait, a moral imperative, an affect, a nurse-patient interaction, and a therapeutic intervention. The conclusion was that the theories should be 'debated, queried and qualified' so that the concepts 'will be applicable' to the art and science of nursing. The authors advocated that there was (indeed still is) a "need for theoretical preciseness, clarity, and parsimony, especially when describing such complex concepts as care and caring", indicating that some of the writing obfuscates (J. M. Morse, Borttorff, Neader, & Solberg, 1994, p. 39). The conceptualisations of *Care* have been added to, including further definitions of *Care* and the concepts are still being debated. The theoretical preciseness and clarity is still lacking and it would seem that the injunction to be parsimonious has been totally disregarded. It is apparent that there is still no consensus in the scholarly writing or the clinical implementation (however implementation is interpreted) of *Care*.

The research on practical caring is as equally large as the theoretical research on *Care* and any attempt to classify the clinical research is best left with the librarians. The settings from Accident and Emergency to Long-term care and patients from newborn to the aged – are all represented. *Care* strategies or how to show *Care*, a combination of how well the strategies work and patients' perceptions of the strategies are not well represented. The patients are not always clearly

delineated, often being combined with the perceptions of *Care* and yet it is the recipients of *Care* who should have as much attention as the clinical setting and the nurses who practise in those settings.

Morse obviously took her own injunction about applicability and clarity in caring theory to heart (J. M. Morse et al., 1994) (first publication date 1991) and just one year later her article on comfort was published (J. Morse, 1992). *Care* is defined as comforting. In an emergency setting the use of 'comfort' was found to be useful as *Care* was too amorphous a concept. Comfort was described as an intervention, which became patient focused and not nurse focused. Once comfort became the focus, it was found that *Care* could give measurable outcomes and demonstrable nursing skills. The importance of the comforting strategies was obvious even though the Emergency Room nurses felt that at the start of the research they did not have the time to comfort (J. Morse, 1992). Later Morse et al challenge nurses to 'find innovative ways' of making patients comfortable (J. M. Morse, 1994, p. 195). In an exploration of the concept, two British researchers took the concept of comfort, and in their analysis suggest that it is a complex concept and that it is still unclear "where comfort sits in relation to nursing as therapy and caring" (Tutton & Seers, 2003, p. 695). I suggest that if patients are comfortable they could conceivably feel *Care* for, and reflected that as a student there was always a strong emphasis by the Ward Sisters on the comfort of the patient. 'Woe betide' the nurse who left a patient who even looked uncomfortable.

The environment in which nurses, and particularly new graduates, practise competes with the holistic view of the patient and prevents them from being able to see the whole person. Arndt comments about this factor almost 12 years ago. "The danger of technology is that it can potentiate a move away from reflection on the meaning of lived experiences, thereby limiting knowledge inherent in practice" (Arndt, 1992, p. 2). The situation has worsened. The current climate, with an emphasis on technology and the dollar, engenders a task approach to nursing that makes *Care* difficult. Arndt argues that it is impossible to define what *Care* is, but that it is conceived and practised in the 'everydayness' of wherever nurses are. It is a simple but profound concept. There is also an assumption that all nurses *Care*. Arndt writes of the 'strength and beauty of practice' as nurses are involved in the 'drama of human concerns and the mysteries of health and healing'. It is the stories

of the everydayness of caring that elucidate what *Care* actually is (Arndt, 1992). Taylor evocatively refers to the 'ordinariness' of nursing (Taylor, 1994).

It is in these images that the nurse is able to care so that there is a *Care*, and like the everydayness of ordinary life, in the living of the experience of disease and disability, *Care* becomes special. The comfort that patients seek is not always physical comfort but a comfort of mind and soul. Put into simplistic terms, if the patient is comfortable in a holistic sense, they are indeed experiencing good care and perceive this to be *Care*, and this makes a difference.

Bradshaw (1999) is emphatic in her writing that there 'should' be a moral virtue of Care and that students should develop the 'necessary virtues' and 'personal qualities' that make a Caring nurse. The point is made that this can only occur if the student nurse is in contact with patients and the health care team by "reviving the role of the ward sister as both teacher and ward leader" and that the student nurse would then learn the "truth of moral precepts by example" (Bradshaw, 1999, p. 5).

One then finds that a full circle has been travelled and the destination is the same point as the departure. If nursing and caring are synonymous, as repeated time and again in the research on *Care*, then the ethic of care need not be debated, for all nurses should be virtuous and all patients are confident and happy with the care and caring they receive in any health care setting. (Unfortunately this is not a perfect world and anecdotally, patients are often not happy with the *Care* that they receive.)

Whatever the outcome, the modern scientific optimism that "ignores the tragic (Athenian) ... and pretends that all problems that concern us are correctable through technology" (Solomon & Higgins, 1997, p. 107) will probably still pervade. This widely held view is particularly prevalent in the health care system and indeed in the whole of Western society. Sax's comment regarding resources and the success of medicine is still as valid in 2005 as it was in 1985.

> Scientific advances have been incorporated into medical practice at an ever-increasing rate. They fortify the belief that no result would be unattainable if only the resources applied to a problem were adequate (Sax, 1984, p. 226).

This expectation ignores the 'tragic' philosophy of the finite existence of life. A cure/cure alternative has replaced the care/cure dichotomy. The technological and therapeutic age has brought with it cost. The visible controversial dollar cost is far

less than the invisible uncountable cost that the patient, left out in the cold, must bear. The patient anecdotally wants care that is *Care*, from nurses (and doctors). The fact that patients want competent nurses (Fagerstrom, 1998; Fagerstrom, Eriksson, & Engberg, 1998; K. Hyrkas & Paunomnen, 2000; K Hyrkas et al., 2000) is fundamental to the safe care guaranteed by the Nursing Council of each state or country. It is a fundamental premise that is assumed. However, the overall perception remains that all nurses are *Care* and the question of whether the patients really want a *Care* nurse remains unclear, a question that will not be attempted in this research.

Joudrey and Gough, (1999) in a qualitative study of second year student nurses and their perceptions of the ethical stance of physicians and nurses, found that the care/cure dichotomy was already firmly entrenched in the students' thinking. Furthermore, there was the strong perception that the caring which nurses carried out was not simply physical care but encompassed an ethic of care (Joudrey & Gough, 1999).

Morse et al. warn in 1994 that there was a need to link nursing practice and theory stating that

> If the relevance of caring to practice and to the patient cannot be clearly explicated... (then,) …..the central core of nursing will need to be reformulated or the gap between theory and practice will be *widened to insurmountable proportions* (1994 p. 39). (Emphasis mine)

Ten years later, Caelli's (2001) conclusion to her research on *Care* in Australia ends with an injunction, that "it is up to nursing researchers to further explore the pragmatics of care and make the parameters of caring more explicit" (Caelli, 2001, p. 32). At about the same time Paley's (2001) scathing article on the archaeology of caring knowledge appeared. It is a thought provoking discourse on the caring literature in which the central premise is that much of the research is a thesaurus-like analysis of the concept of caring. The caring knowledge is, he argues, preparadigmatic and is "destined to remain elusive - permanently and irretrievably" (Paley, 2001, p. 196). If it is elusive then this *Care* cannot be taught and generations of patients are destined to have uncaring care. It simply is not elusive as previous

generations of patients have experienced this *Care* and know that it exists. How is *Care* enacted?

The synergy between nursing and Caring depends on the theoretical perspective of the researcher and their interpretation of nursing. If Caring and nursing are indeed synonymous then the synergy is complete and there is no divide. If there is a divide it is one that is probably academic or what is commonly called the theory/practice gap and Morse's warning that the gap will reach 'insurmountable proportions' should be taken seriously.

Conclusion

This literature review sought to encapsulate the notion that *Care* has not always been Caring. Even though the teaching of Christ served to dramatically change the way that the suffering patient was cared in nursing (however it was interpreted), the Christian imperative to Care was not always followed. The Christian imperative was necessary as the care of those who were diseased, disfigured, and infected was challenging as disease dominated. History of nursing does not reflect the hard work and messiness of disease and death that continued through to the Therapeutic Revolution, a mere fifty years ago. That disease and death were an integral part of daily life and illness/morbidity tedious for the patient and the concomitant fact that nursing for the nurse was for the most part onerous and time-consuming is often forgotten. The history of nursing is sanitised as the vocation to nursing is emphasised. This vocational model of *Care*, inspired by a devotion to Christ and the Christian teachings, served nursing, as it was known, for centuries. However, the noble altruistic devotion of 'nurses' was limited as populations increased and the scourge of disease and epidemics ravaged populations.

The ravages of disease and the labour of nursing are often forgotten in today's climate of easy cure due to the Therapeutic Revolution. This revolution and the later Technological Revolution brought enormous changes to nursing and the way in which the patient was nursed. For a short while the economy, three hourly intra-muscular antibiotics, with the dramatic cures, brought interim changes in which there was sufficient time and energy to be devoted solely to the patient and a short Golden Age of *Care*, came and went.

The easy cure has brought cost. The increasing cost of the newer therapeutics (although the need for hospitalisation decreased) and enhanced high-technology is not only counted in dollar terms. The climate of stress and the increased need for educated nurses has changed the 'economics' of *Care*. The ethics of Who lives? Who dies? and Who Pays? adds to the strife of the persistently changing health care scene. The position of nursing in the ever-evolving health care milieu is problematical. The *Care* ethos and debate is one that is principally theory driven, with little attention paid to the practicalities of the meaning of *Care* to the customer.

In the nursing literature prior to the 1970's, there is no distinction between Caring and nursing; it was assumed to be there. The notion of vocation was still firmly entrenched, with an implicit endorsement to Care about/for. The theory practice divide, a product of the move to university for nurse education, is manifest in the nexus nestled within the conceptual interpretations of Caring and Nursing. The theoreticians call it *Care* and the clinicians, Nursing.

Although this theoretical domain of nursing has become entrenched in the universities in Australia it has also formed a new basis for dialogue. I posit that dialogue is not enough. The need to *Care* is undisputed and the dialogue needs to be based where *Care* is needed, *in* nursing practice. The specific strategies used to show *Care* are numerous and generic, how *Care* can be enacted is open to question. It is the *Care* enactments and the if/how they can be taught that this research is about. It is to these questions that this research will now turn.

Chapter 3: Participatory Research

Introduction

Participatory research acknowledges the importance of the individual and the sacredness of human existence. It is an acknowledgement of the universe as a cosmos in which humanity takes a position of importance and as Heron (1996) reiterates the principal concept of any project should be 'transformational'. Reason and Bradbury (2001a) conclude their introductory discussion on participative inquiry with the following,

> …practical inquiry of human persons is a spiritual expression, a celebration of the flowering of humanity and of the co-creating cosmos, and as a part of a sacred science is an expression of the beauty and joy of active existence (p. 11).

The concept of 'celebration' is as new to research as the concept of participation. In order to understand this more fully, and in keeping with the historical and reflexive nuances explored in the literature review, there will be two short detours from the normal patterns of discussion on the philosophical foundations of the selected research method.

The first detour is a brief reflection as to why I chose the participatory paradigm. The second, a longer detour, is into some of the complexities of research into disease. While the historical background is scientifically oriented its importance to nursing was and still is influential. Nursing care was dramatically changed with the advent of the Therapeutic Revolution, and perhaps more importantly to remember, much of the early nursing research was based on the scientific (positivist) paradigm. The watershed in the treatment and management of disease that occurred in the middle of the Twentieth century was the result of relentless research in laboratories and the participation of patients in the early drug trials. However, it is irrefutable that without the participation of patients, the health care system would have stayed in the Dark Ages forever.

The first detour – two concepts and two phrases

I reflected on the paradigm and the reasons why I had chosen this philosophy. There are two key concepts in relation to my own ideology and the choice of Participatory Research. These will be discussed briefly, prior to giving Heron and Reason's (1997) two phrases that capture the two concepts and thus also my own personal philosophy for this research.

The first concept is my implicit recognition of the importance of the other. Within this research there are two groups of others, the patients and the GRN group, and inherent in this group are student nurses of the future. The patients are the first others, and in essence why I am still nursing. I want their hospital stays to be different – in spite of the pain, anxiety or frustration; I want their experience to be a positive one. Not for every patient, that would be unrealistic, but the potential for human flourishing is there. The second others are the GRN group and students, the RN of tomorrow. The research is in essence not mine only, but it also belongs to the GRN and to their nameless patients (and my students) who have become part of my reality of the *Care* world.

The second concept is a desire to change practice, as "what we learn about our world will be richer and deeper if this descriptive knowledge is incidental to a primary intention to develop practical skills to change the world" (Heron & Reason, 1997, p. 7). Not that I want to change the world, but I do want to make a difference, and in doing that, change my corner. The research is based in clinical reality as well as in the university. I sometimes describe myself as being a pragmatist having one foot in a university and the other one still in clinical reality. The move to universities for nursing education has been a necessary and vital step in the preparation for registration. However I/we cannot be so heavenly (tertiary) minded that we are of no earthly (clinical) use.

An essential element of participatory research is critical subjectivity, which "involves a self-reflexive attention to the ground on which one is standing" (Heron & Reason, 1997, p. 7). Although the concept of critical subjectivity will be discussed later, I wanted to formally include myself in the research process. The notion of participative research allows this, as the researcher takes part in the co-creating of a cosmos of knowledge. My years of teaching and nursing would impinge on the study and in order to do this ethically, there was a need to choose the research

paradigm carefully. My reflections are included throughout as part of the process of discovery.

The two phrases that best sum up the focus of participatory research are those from Heron and Reason's (1997) seminal article, "our inquiry is our action in the service of human flourishing" and "participatory research is thus essentially transformative" (p. 11). I believe human flourishing can be greatly assisted in a climate of Caring. Hence my interest in how Caring can be transposed into practical activities or enactments in a nursing context. If a way is found to *Care*, the nursing profession will be able to be part of a 'transformative' practice that aids 'human flourishing'.

The second detour, a historical glimpse of research in disease, is longer than my reflection on why the Fifth Paradigm was chosen. It is, however, of necessity, brief. If there had been more openness to scientific medical research two centuries ago, where would medical science and the patient be today? I also asked what quality of life would be for some patients if qualitative research had been as important then as it is now?

The second detour – research into disease

Eikeland (2001), in a discussion on the history of research, maintains that the beginnings of an essentially practically based research (participatory research in particular) dates back to the philosophical traditions of Aristotle. In Ancient Greek, the range of different words that were available for 'knowledge' gave a far greater flexibility in debating the different kinds of wisdoms. Embedded within the essence of knowledge, all knowledge has an essentially practical aspect that has been lost in the "spectator context" of scientific research (Eikeland, 2001, p. 146).

During the Seventeenth Century, medical research was, for the most part, at the bedside and in the mortuary. The problems with the ethical dilemma between the acquisition of knowledge (research involving the patient) and the problem of suffering and how to relieve the patients' symptoms predominated. Doctors relied on their expertise gained at the bedside and "swore by the tacit knowledge at their fingers' ends, and in their heads" (Porter, 1997, p. 525) and continued to function as they had done for hundreds of years. It is not difficult to read into this pre-scientific era the epistemological foundations of participatory research. The patients themselves were active participants of an informal research process, as the doctor

made home visits and became well acquainted with the family. The family doctor was in fact doing participatory research on an informal level.

At the start of the Therapeutic Revolution, clinical trials of drugs (Penicillin and Streptomycin) were important and necessary and demanded an active patient participation. Participation was not a problem, neither for the patients who lived nor for the scientists who only cared about a positive result. The patients in the control group would have died in any case. That was not a problem…then. The Florey rose commemorates the discovery of clinical Penicillin by a team of Australian scientists led by Florey, but it is also a tribute to the participation of a patient, dying with septicaemia from a rose thorn, who was the first person to receive Penicillin. The policeman improved dramatically when given Penicillin – then died – there was not enough of the new drug (Porter, 1997). The policeman's participation had been crucial to the ongoing development of penicillin and the Therapeutic Revolution. Formal scientific (participatory) research was created.

Once medicine became involved in the scientific tradition, the positivist paradigm became entrenched. Randomised Control Trials (RCT) became the method of choice in clinical research and were particularly important in the testing of new drugs. In the early years, clinical trials of drugs (Penicillin and Streptomycin) were critical.

Miller and Crabtree (2000), both doctors, argue strongly that in current medical research the "complexities and individualities of suffering are suppressed" in the framework of RCT and scientific (purely quantitative) research. They are critical about RCT and the one-eyed research methods used by the power brokers of the corporate bodies in the biomedical conglomerates that exclude the important qualitative dimensions of the participants. They are convincing in their presentation of the facts that "stories are hidden" and "suffering is standardised". The "public discontent" and "missing evidence" issues are vital to the argument that there is a qualitative aspect that must be incorporated into all clinical research (p. 608). They concede that some of the necessary qualitative elements are now included in clinical research but that it is still only patchy and that "clinical research needs to be open to all the…possible sources and types of knowledge" (p. 608). They conclude with a warning that the researchers must beware of the "idolatries of measurement" and control and that clinical research needs to take risks and restore relationships to the world of both the patient and the clinician (p.626).

The 'researched' became a passive contribution of the self, sometimes invited and sometimes unknowingly participating in research for the betterment of humanity. Miller and Crabtree (1994) are scathing in their condemnation of purely quantitative clinical trials where the patient's story is lost and "the research tends to be a-theoretical, hospital based, and disease oriented". They further argue that qualitative clinical researchers need to learn the discipline of seeing with three eyes – the biomedical eye, the inward searching eye of reflexivity, and a third eye that looks for the "multiple, nested contexts that hold and shape the research question" (p. 611). True participatory research is the active involvement of all those involved in a particular research project, it is research using the 'three eyes', to delve into the research to uncover the true meaning, if indeed the real truth can ever be known. Charlesworth (1998), from a different perspective, indicates that the dark side of participation was that death was transformed from a human and religious phenomenon into a "problem of bodily function". Attention was directed to the body, and as with so many aspects of nature, the body became a machine that could be repaired (Charlesworth, 1998, p. 121).

It is worthwhile to point out that, historically, nursing has not been research-oriented and it has taken the transfer to university education to generate an active interest in research. In a discussion on the move to higher education, late last century, and the fact that nurses were forced into a position in which nurses and nursing had to conduct research, Lawler (1995) has this to say.

> Matters of a 'higher' scholarly nature were not things that nurses individually or collectively had enjoyed; nor were they universally accepted as the rightful business of nurses (p. v).

It is a reflection on the past, but also as the shelves of the nursing libraries and the content and number of journals are scanned, indicative of the extraordinary progress nursing in Australia has made in the past twenty five years.

Participatory research

The participatory research paradigm will be used as the worldview in which this research is located. Although it is the participative aspect of the paradigm that was a reason for its selection, it is also the axiology that was involved in the decision

making process. Heron and Reason (1997, p. 14) summarise the axiology, as "Practical knowing how to flourish with a balance of autonomy, cooperation, and hierarchy in a culture is an end in itself is intrinsically valuable" or as Heron (1996) phrases it, "Practical knowledge, knowing how, is the consummation the fulfilment…of the knowledge quest…it affirms what is intrinsically worthwhile, human flourishing by manifesting it in action" (p. 35). It is the aspect of the knowledge quest, finding the *Care* actions, that will be worthwhile for the patients. In the practical doing of the *Care* the RN will grow and flourish in their own being.

The beginnings – "vivencia" research

In 1977 the first World Symposium of the International Sociological Association adopted Participatory Research (PR) as a new methodology. It was at this symposium that the researchers adopted *vivencia* (life-experience), meaning "empathetic" "togetherness" or "identification" attitude, as its philosophical underpinning. In essence *"vivencia"* research was a meeting of the researcher and researched without the use of expensive research and "scholarly arrogance". It was agreed that the philosophy of PR had in effect a wider application than just a new methodology; it was a "philosophy of life" (Borda, 2001, p. 31). Kemmis and McTaggart (2000) make the point that participatory research is actually an alternative philosophy of social research and that it is often associated with social change in the Third World.. In other words, the researcher sees that there is a problem that is based in the realities of an underprivileged society or community, and together with the community seeks to resolve the problem. Hospitals are not underprivileged but they are community, and the patients are needy, not only in terms of physical care but for support and *Care*. From this perspective as well, the philosophy of the participatory paradigm fits this research.

Lincoln (1995) would appear to have strong personal leanings towards the use of a participative model, as she is critical about the standpoint of researchers with the researched and comments that,

> … the somewhat dark side of research hides the fact that most of our research is written for ourselves and our own consumption, and it earns us the dignity, respect, prestige, and economic power in our own worlds that those about whom we write frequently do not have (p.8).

She then refers to an in-press article of hers where she asks the question, "who owns the lives that we use, however sacredly and respectfully" the research is written (Lincoln, 1995, p. 8).

Heron (1996) asserts that, "Qualitative research is a *social* science, about other people in their own social setting" (p.10) (Heron's italics), indicating that it is people who are at the heart of qualitative research. In spite of these concepts there is some contradiction to this social science philosophy in that action research and its association with social science is still "heavily influenced by conventional scientific thinking" (Bray, Lee, Smith, & Yorks, 2000, p. 32). This is not surprising; participation in sociological research at the turn of Twentieth century was in name only. Indigenous peoples were objects of research. Early qualitative (social) research was primarily ethnographic and the 'noble savages', 'natives', and 'primitives' in 'distant lands' were essentially the researched and the researcher was required to be objective, albeit in a technical or scientific sense. The role of the researched was passive and submissive and it would seem that this passivity and submissiveness was total as they eagerly shared their culture in whatever form or content they thought was required. Although there were the obvious problems of understanding and interpreting due to language barriers, the lack of active involvement by the researched is an opportunity that has gone forever. The loss of entire cultural heritages that could have been gathered in a truly participative research is lamentable.

There are corollaries here between nursing, medical research and the early social research. The researched (patient) is eager to please; eager that they will not be left out when the rewards (cures) are handed out. Participation was (or, is it still *is?*) often relative to the rewards on offer. It took nine months to recruit eight patients to participate in a study on patients' perceptions of hospital care (and implicitly *Care*) in the southeast of the United States of America. No mention is made as to why the recruitment was so difficult (Schmidt, 2003).

Participatory research acknowledged

Participatory research was finally acknowledged as a separate important methodology by being included in the second edition of the *Handbook of Qualitative Research* (Lincoln & Guba, 2000), that acknowledged the seminal article of Heron and Reason (Heron & Reason, 1997) and placed participatory research into a new paradigm, the Fifth Paradigm. This does not reflect the historical development of participatory research or the important work by Heron and Reason over some twenty years.

Heron and Reason's publications reflect a willingness to help in troubled areas of the world and a passion to share that vision with others in academia. This is best summed up by Reason when writing with Bradbury they indicate a desire to present a model of inquiry that would take research out of the "ivory tower" and the "positivist model of science, research and practice" (Reason & Bradbury, 2001b, p. xviv). This philosophy is reflected in their other work (Heron, 1996; Heron & Reason, 2001; Reason, 1994, 1998; Reason & Bradbury, 2001a, 2001c). Heron and Reason are not consistent in their use of the nomenclature and use the words 'participatory inquiry', 'co-operative inquiry', and 'participative paradigm' in different contexts but meaning the same concept.

Heron's in-depth text, *Co-operative Inquiry* (Heron, 1996) has been used for the exploration of the theoretical background of participatory research that underpins this research. The need to distil some of their writings into a single chapter means that some of the nuances of meaning may be lost. The fault is entirely mine and does not reflect in any way the scholarly interpretation of participatory research that is dealt with in their extensive works.

Participation

The essence of PR is captured in the phrase that it is "*with* people not *on* them or *about* them" (Heron, 1996, p. 19) (Heron's emphasis.) Heron and Reason (1997) write that although they had been working within a participatory framework for many years it had been only recently that they had "articulated this perspective as an epistemological and political principle" (p.2). They do not define the paradigm; in fact it is only an interpretation of the paradigm that is given as it is almost assumed that the reader does not need a definition. Heron's own 1996 interpretation of participatory paradigm is rephrased in 1997,

> …within the participative worldview the primary purpose of human inquiry is practical: our inquiry is our action in the service of human flourishing. Our knowing of the world is consummated as our action in the world, and participatory research is thus essentially transformative. Although some inquiry projects may be primarily information and result in propositional knowing, transformational projects are primary (Heron & Reason, 1997, p. 11).

Heron (1996) further emphasises the "primacy of the practical" (p. 165) which is a central focus of this research. Thus the essence of the participatory paradigm is that the lines between the researcher and the researched become blurred as they form a partnership in pursuit of a common goal. In some ways it could be termed a pluralist approach to research, which is advocated by a number of nurse researchers (Bottoroff, 1991; Stember & Hester, 1990). This pluralist approach is also evident in this research.

Heron (1996) defines what is now known as PR as a vision of persons in reciprocal relation using the full range of their sensibilities to inquire together into an aspect of the human condition with which the transparent body-mind can engage (p. 1).

Philosophical foundations of this research

Denzin and Lincoln (2000) attest to the importance and essence of research in the qualitative paradigm that can only be interpreted in the context of the "three interconnected generic activities…ontology, epistemology and methodology", although "behind these terms stands the personal biography of the researcher" (p. 19). Thus, there are two domains that must be addressed, firstly the researcher and secondly the ontology, epistemology and methodology of the participatory paradigm.

The 'personal biography of the researcher' is the first important element in participatory research. The interdependence of a subjective-objective reality in a participatory world – the ontology as interpreted by Heron, Reason and Bradbury (Heron & Reason, 1997; Reason & Bradbury, 2001a), is fundamental to this and other participatory research. Although it could be argued that the person as

researcher is a pervasive element in all qualitative research, it is a concept that is sometimes ignored, to the detriment of the research.

The inclusion of the researcher in this methodology is fundamental to the methodology and the way in which the validity of the process is evaluated. The personal biography is primarily acknowledged by the use of reflection. Heron (1996) identifies four types or forms of reflection – the descriptive, evaluative, explanatory and applied. Descriptive reflection is used by the Graduate Registered Nurses (GRN) as they reflect on the Caring enactments of the RN. The explanatory phase is, according to Heron, a "higher order form of thought" subdivided into seven different sorts of thinking. It is hermeneutical thinking, in which phenomena are acknowledged and explored in terms of the past and current "values, norms and belief systems" (Heron, 1996, pp. 142-144). It is a concept that will extend throughout this research through the use of reflections indicated by a heading and markers that indicate the start and finish of the reflection. Explanatory reflection is used extensively in Phase III of this research.

The second domain that needs to be articulated is the ontology, epistemology, methodology, and axiology of participatory research, as articulated by Heron and Reason. It is one of simplicity and at the same time one of complexity. The simplicity is evident when the ontology, epistemology and methodology together with the overriding axiology are seen as a whole. The complexity is seen when the ontology, epistemology, methodology and axiology are individually scrutinized (Heron & Reason, 1997).

In attempting to describe the important philosophical entities of ontology, epistemology and methodology it must be remembered that they are 'intimately related' (Martin-McDonald, 2000). The interconnections and intimate relationship between these three elemental concepts are succinctly defined,

> Ontology, epistemology and methodology are intimately related. The first involves the philosophy of the essence of the world, the second involves how we come to know the world and the last involves the practice of coming to know the world (Martin-McDonald, 2000, p. 146).

However, when ontology, epistemology and methodology need to be defined, explained or "sketched out" within a paradigm in terms that can be understood, they

are by their very nature, "richer" than what can be explicated in propositional terminology (Heron & Reason, 1997, p. 2). In the context of the Fifth Paradigm the ontology, epistemology and methodology are so closely linked that it is sometimes difficult to differentiate and clearly define these central concepts. In some of Heron and Reason's writing the definitions of the concepts vary (Heron, 1996; Heron & Reason, 1997, 2001; Reason, 1994; Reason & Bradbury, 2001a, 2001b, 2001c). The definitions that follow are those that have the most clarity.

Ontology

Heron (1996) defines the ontology as affirming a,

> Mind-shaped reality which is subjective–objective: it is subjective because it is only known through the form the mind gives it; and it is objective because the mind interpenetrates the given cosmos which it shapes (p. 11).

It is also the definition given in Heron and Reason's seminal interpretation of the Participatory Paradigm. In dealing with the subjective-objective reality and what that reality is, Heron "suggest(s)" that this "mind-shaped reality" or ontology is a "congruence between the four ways of knowing," (Heron, 1996, p. 164). It is important to note two things. The first is that he calls the explanation a suggestion, and thus it must be noted the fluid nature of some of the defining concepts of this paradigm. Secondly the way in which subjective-objective reality is described is entirely dependent on the epistemological interpretation of knowing. This illustrates the "closely interwoven, interdependent and interdefined" notion of the ontology, epistemology and methodology (Heron, 1996).

Heron's (1996) definition quoted in the above paragraph is not as clear as Reason and Bradbury's later definition, although they do not include the important aspect of a subjective-objective reality. Reason and Bradbury (2001a), conclude their discussion of the ontology with a longer definitional summary that encapsulates the paradigm's ontology.

> We live in a participatory world. There is a primordial givenness of being in which the human bodymind actively participates in a co-creative dance. This gives rise to the reality which we experience. Subject and object are

> interdependent. Thus participation is fundamental to our being, an *ontological given* (p.8).

In the worldview of participatory research, the central premise is a participatory reality, described as being evolving. Thus it is not a static construct but with emerging changes as the researcher and researched embark on a "co-creative dance". These words are evocative, forming an image of people moving and working together rhythmically, changing to the music of the environment, and in the doing creating new forms and movements in response to the music. The researcher and participant work together in the processes of generating new knowledge. Revolving around this central participatory axis, which is in itself evolving, are four lesser but still essential characteristics or concepts that Reason and Bradbury (2001a) call "dimensions". These dimensions are the constructions of meaning and purpose, relational ecological form, an extended epistemology and a practical being and acting (Reason & Bradbury, 2001a). Although these four dimensions are dealt with as essential parts of the ontology they extend into the epistemology as well as specific methodological interpretations. This is entirely congruent with the philosophy of participatory research in that it has a 'holistic' approach (Reason & Bradbury, 2001a, p. 6).

Heron (1996) uses a conceptual model in his explication of the philosophy of participatory research. The model has as a central premise the concept of participation and is flanked by two wings (and I imagined a butterfly), an epistemic wing that deals with truth-values and the political wing that is essentially axiological and deals with being-values. (The emphasis is mine underscoring the difference between the two.) The epistemic wing deals with the ontology, epistemology and methodology while the political wing deals with the worthwhile-ness of human flourishing. Heron maintains that this flourishing can only be enabled when there is a mutual balance of autonomy and co-operation between the researcher and the researched. (Heron, 1996, p. 11) The imagery is evocative, the 'wings' of a butterfly pausing in flight on an early summer morning, relishing dew and nectar as it lightly goes from flower to flower. Like the butterfly, research in this paradigm is only successful when there is a perfect balance between the two wings. Later Heron, together with Reason (1997), take a slightly different approach and indicate that

participatory research rests on two "participatory principles", that of an "epistemic participation and political participation" and then they define what they mean.

> The first means that the researchers in their own experiential knowledge ground any propositional knowledge that is the outcome of the research. The second means that research subjects have a basic human right to participate fully in designing the research that intends to gather knowledge about them. It follows from the first principle that the researchers are also the subjects; and from the second principle that the subjects are also the researchers. (p.8)

Participation has not always been an ontological foundation for nursing. The nurse has traditionally been seen as 'doing for' the patient, or the patient has been under the aegis of the nurse. The nurse was in a powerful position not only in the doing but also in the deciding for the patient. The 'co-creative dance' of nurse and patient does not fit easily with nurses and some nurse-researchers. Among a number of proposed theories on nursing in the 1960s and 70s was Orem's (1985) theory of self-care. In a recent study of instructors teaching into a master's programs in the USA (home of the nursing theories) it was found that for the most part, the respondents felt that there should be more emphasis on practical application and less on the discussions of the grand theories. (McEwen, 2000) Perhaps, in today's climate of economic rationalism, the self-care theory may have been more acceptable. Self-care, or in the context of this discussion, participation, was not (in the past) part of nursing practice (Orem, 1985). In this era, self-care remains for many a concept. Although self-care is eulogized it is still not given full support by the nursing profession.

REFLECTION

> I remember the patients of my student days. Surgical patients were not allowed out of bed for two or three days and the patients with a myocardial infarct were nursed in bed for six weeks. Even visiting hours were restricted and the visitors" bell signaled that there was only five minutes left of the short single hour of visiting. Participation in their own care by the patient (or the family) was an activity that student nurses simply had not heard of. There was if anything sometimes a role reversal. Lunchtime reminiscing confirmed it.

> Patients helped nurses. Once the patient was well enough the patient participated in the care of others in order to help the nurse. The willing patient who gave out the suppers for an overworked nurse was a godsend. Students still find it difficult to accept the notion of self-care. After all, the patient is under the aegis of the nurse and the nurse is under a moral obligation to do for the patient. Caring *is* for some nurses 'doing'.

Although holistic nursing and patient education were a pre-cursor to what should be participative care between the patient and the nurse, it seems that the tradition of the patient being subservient while in hospital remains. It is from this background that a nurse-researcher would have to shift from an ontological workview of the traditional positivist to a participatory stance that is "systemic, holistic, relational, feminine, experiential," with a "defining characteristic that is participatory" (Reason & Bradbury, 2001a, p. 6). Perhaps what is most important to remember is that in nursing and participative research processes there is a "privileged space and place we hold in the lives of humans" (Watson, 2005).

Epistemology

The definitions of epistemology vary, as do the philosophical interpretations of what epistemology is. Martin-McDonald's (2000) pithy "how we come to know the world", is clearer than other interpretations of what epistemology is, such as Guba and Lincolns question about the relationship between the knower and the known, and the definition within Carper's question "What is the *conceptual structure of knowledge* in nursing?" (Emphasis mine) (Carper, 1978; Guba & Lincoln, 1994; Martin-McDonald, 2000).

Prior to the discussion of the epistemology of participatory research, it is worthwhile to briefly mention the status quo of an epistemology of nursing. It appears that nursing is still struggling with the concept of defining what the epistemology of nursing is. Carper's 1978 'fundamental patterns of knowing' of nursing is still quoted, being, it seems, the seminal attempt at defining the epistemology of nursing. There are, it is posited, four fundamental patterns of knowing in nursing. They are empirics – the science of nursing, esthetics – the art of nursing, personal knowledge in nursing, and ethics – the moral component (Carper, 1978, p. 253). Like Heron and Reason, Carper advocates that although she has

articulated four patterns of knowing, they cannot stand alone and are not mutually exclusive. There are links between the two epistemologies; and while it is not easy to align the knowing of each, as the way in which they have been defined precludes an exact match, the intent of the categories is present.

Cheung's (1998) research is a qualitative study into the ontology and epistemology of caring from the perspective of a group of Australian nurses. The study found that caring is a way of being, benefits patients, is a way of understanding nursing and developing nursing knowledge, and that on reflection nurses are further able to articulate what caring is. Caring thus expressed, Cheung posits, "can be considered the epistemological foundation of nursing and understanding the way of caring in nursing practice" (Cheung, 1998, p. 232). Watson clearly articulates the ontology of Caring Science, and implicit in this is the notion that it is what nursing should adopt, which "is grounded in a *relational* ontology within the universe, which in turn informs the epistemology, methodology, pedagogy, and praxis of nursing" (Emphasis mine) (Watson, 2005, p. 29). I posit that this relational ontology has been an integral part of Watson and other writers on *Care* for decades, but to this point has not been fully articulated, and it is likely that this relational philosophy will eventually generate a consensual ontology of nursing.

The straightforward dictionary definition of epistemology is simply that it is the theory of knowledge (Moore, 1999). It is this definition that is used by Heron and Reason as they define their epistemology as being "– a theory of how we know" an extended epistemology, as it "reaches beyond the primarily theoretical, propositional knowledge of academia." This extended epistemology is a combination of four types of knowing; experiential, presentational, propositional and practical as being the defining feature of participative research (Heron & Reason, 2001, p. 183). The use of the word combination is not entirely correct, because they are separate and distinct, yet are dependent on each other.

These types of knowledge, with which the knower experiences and thus becomes aware of the world, are a challenge to the use and development of a critical subjectivity and intersubjectivity discussed more fully under the methodology section. This critical subjectivity is essential to the interacting knowing of the world that is being researched. It is not, the writers emphasize, to be clouded by "restrictive and undisciplined subjectivity" (Heron & Reason, 1997, p. 6). The point is that the researcher is to be aware of the different types of knowing in order to be

empathetic and sensitive in the real world in "creating meaning" and not just researching as an academic pursuit (Reason & Bradbury, 2001a, p. 9).

The central issue of their interpretation of knowing is that, in the interacting of the knowings, there are many ways that enable relationships to be formed through "participation and intuition" (Reason & Bradbury, 2001a). In an earlier text, and in a slightly different exposition, Heron (1996) posits that there is the need to have the professional knowledge (or deep understanding in the experiential, presentational and particularly the propositional forms) before it can be translated into the intensely practical form.

Heron (1996) describes the epistemology of knowing using two conceptual models, a pyramid and a circuit (also indicating that in another text he uses a spiral model to depict holistic knowing) (p. 52). The pyramid model is the one that will be used in this discussion. There are four levels in the pyramid, each distinct yet overlapping the level above, signifying the importance of each level that is built on and sustained by the level beneath it. The base of the pyramid, experiential knowing, is followed by the presentational, followed by the propositional and at the top of the pyramid, the practical. The pyramid model is also used to illustrate the important axiological aspects of participative research, truth and being values. Graphically they are represented as upward arrows (consummation of being values) and downward arrows (grounding validation of truth values) moving through the four types of knowledge. These two value constructs are conceived as having "bi-polar congruence" in which truth-values are grounded in experiential knowledge, at the base of the pyramid, and being-values are consummated at the apex in "concerted and excellent practice" and it is this excellence in practice that "crowns their world with the value of human flourishing" (Heron, 1996, p. 167). Thus the model is not a static one as there is a congruency cycle(ling) through (up and down) the levels of knowing. In the research process itself, if these four types of knowing are congruent, the validity of the inquiry is acknowledged (Heron & Reason, 2001).

The discussion on the four types of knowledge will each be prefaced by the definitions given by Heron and Reason in the *Handbook of Action Research* (Reason & Bradbury, 2001c). The chapter is one of their latest expositions of the participatory paradigm and the definitions are the clearest.

Experiential knowledge

> *Experiential knowing* is through direct face-to-face encounter with person, place or thing; it is knowing through the immediacy of perceiving through empathy and resonance (Heron & Reason, 2001, p. 183).

Experiential knowledge, at the base of the pyramid, provides the grounding of the ongoing development of the other knowings. It is also earlier described by Heron as "participative knowing" (Heron, 1996). The above definition gives a clearer understanding to the words "empathy and resonance". Experiential knowledge is also described as being subjective-objective. In other words this knowledge is to be able to "image" itself in the mind of the researcher, subjective, and able to "know that it is there", objective. The researcher, as a result of this encounter, begins to formulate the base for further conceptual frameworks and the development of propositional knowing. In summary, "experiential encounter with the presence of the world is the ground of our being and *knowing*" (Heron & Reason, 1997, p. 2) (Italics mine). I wondered if this experiential knowing was the same as the intuition of the expert nurse as articulated in Benner's work on *Care* (Benner, 1984; Benner & Wrubel, 1989).

Presentational knowledge

> *Presentational knowing* emerges from experiential knowing, and provides the first form of expressing meaning and significance through drawing on expressive forms of imagery through movement, dance, sound, music drawing, painting, sculpture, poetry, story, drama and so on (Heron & Reason, 2001, p. 183).

Presentational knowledge emerges from experiential knowing, and is often couched in a symbolic way in some art form. It is as if the experiential knowing takes on a form. Heron and Reason (1997) describe it as a meaning that emerges at a particular moment of time or as an intuitive grasp of something that the researcher has been seeking and who is now able to present this new "knowing" in a tangible form. They also suggest that "It clothes our experiential knowing of the world in the metaphors of aesthetic creation" (p. 6). It explains perfectly what is meant by the phrase, nursing is an art, as it is more than the practical knowing. Those RN who

have personally experienced the trauma of surgery or a death in the family (experiential knowing) are often the RN who are able to consummate the practical because they have grounded their knowledge at the base of Heron's knowledge pyramid. They are the RN who have a depth of understanding with an ability to clothe their work in aesthetic creations, whether it is a complex clinical procedure or simply making a patient comfortable.

Propositional knowledge

> *Propositional knowing* 'about' something, is knowing through ideas and theories, expressed in informative statements (Heron & Reason, 2001, p. 183).

Propositional knowledge is the articulation of the knowing and is an abstraction or conceptualization of the knowledge that is gained from the experiential. The propositional articulates what needs to be known, always uses language and is at all times grounded in the experiential. The propositional knowing is the conventional proposition of the traditional inquiry. As a result of the innate links to the two knowings, below and above, propositions are built on the foundations of the presentational forms and also form and become the bedrock for the practical forms of knowing. Propositional knowledge becomes a knowing that is verbal and informative, and is knowledge that is interpretive, explanatory or used to theorize.

Practical knowledge

> *Practical knowing* is knowing 'how to' do something and is expressed in a skill, knack or competence (Heron & Reason, 2001, p 184).

In truly participative research the end focus is the practical (Heron, 1996; Heron & Reason, 2001). Practical knowing "(F)ulfills the three prior forms of knowing, brings them to fruition in purposive deeds, and consummates them with its autonomous celebration of excellent accomplishment" (Heron, 1996, p. 7). Heron refers to this as being "the primacy of the practical" (Heron, 1996, p. 165). This practical knowing is action that is grounded in the previous forms of knowing as well as being a consummation of the knowledge generation that preceded it.

This concept of practical knowing and the way it is built on previous knowledge in an epistemological sense is one that has been explored in nursing and can be likened to what Benner (1984) calls knowledge that is embedded in practice (expertise) (p. 3). Jean Watson (1999) uses a similar concept in her philosophical interpretation of caring and nursing, and is illuminating in this context. She argues that nursing is at present in (or should be in) a period that is transpersonal and healing, calling it Era III/Paradigm III. The suggestion is that there are paradigms in nursing that have moved beyond the essentially objectivism of Paradigm I and the human-science of Paradigm II, and that praxis is an integration of doing, knowing and being within a caring paradigm. Although the initial defining phrases of experiential knowing by Benner and the explication of Paradigm III by Watson are similar, the adjectives used by Reason and Bradbury (2001a) are so descriptive that it is worthwhile using them in order to ensure the original intent is maintained. They claim that this "kind of in-depth knowing is almost impossible to put into words" (p. 9), and that experiential knowing is not limited to a socialising with other people but includes places, events and other processes or 'things' and uses the words 'empathy', 'resonance', 'productive imagination and 'extrasensory perception'.

One has to understand at a deeper level before practical knowledge can be exercised. I understood that there was a deeper truth in the philosophical interpretation of experiential knowledge. Practical knowledge needed to be truly experienced before it can be 'consummated' in 'excellent practice'. The 'ah-ha' experience was, however, deeper than that. It was an epiphany that seemed to be saying that patients under the aegis of a nurse will not, or in fact cannot, receive *Care* unless (for the nurse) there is true/valid epistemological practical knowledge that is grounded in the three previous types of knowing as espoused by Heron (1996) and Heron and Reason (1997) above.

Having understood and explicated the epistemological foundations of participatory research, the essence is then situated in the key processes of the methodology.

Methodology

The methodology of the participatory paradigm flows from the ontology and epistemology, with an interplay of 'critical subjectivity' and 'critical

intersubjectivity'. All the participants are engaged in 'democratic dialogue' as co-researchers as well as co-subjects (Heron & Reason, 1997, p. 8).

Heron describes how the epistemological foundations form the methodology itself. The links between the four epistemological knowings and the methodology are straightforward, although the method is not prescriptive. Practical knowing is at the pinnacle of Heron's pyramid and it is this new knowledge, acquired through the research cycling and the cycles of knowledge, that the practical knowing can be enacted in and for the enhancement of human flourishing.

Heron and Reason (2001) give examples of how research was completed in a variety of ways. These ranged from doctors meeting for a few weekends over a long period, to an inquiry in which single working mothers explored their problems maintaining breastfeeding in weekly meetings.

Hall (2001), on action research in the participatory paradigm, says that she has "tried to avoid getting drawn into discussions about methods and techniques", but does give a number of strategies that she has used indicating that the formulation of knowledge can in fact be generated in a "myriad of socially constructed and creative ways" (Hall, 2001, pp. 173-175). In spite of this apparent openness to a set method there are three themes that are central to all the discussions on participatory methodology; these are participation, critical subjectivity and intersubjectivity, and research cycling. These three important aspects will be discussed separately, although the division is artificial and the interconnectedness is essential.

Participation

Participation is elemental and without active participation the philosophy of participatory research no longer exists. The principle of participation is dependent to a greater or lesser extent on the participants (both researcher and researched) and *their* needs. Heron (1996) posits that there are in fact two levels of need and uses examples from large research projects that he has been involved in. A primary need, such as a model of holistic practice for doctors or the problems faced by single working mothers who want to breast feed. The secondary needs are the part of the everyday living of the participants that need to be taken into account. If these needs are not considered in a genuinely humanistic way it can be argued that the participatory principle is not being recognized and the participants" commitment could be questioned. It would for instance be inappropriate to try and get busy single

mothers, with no support, away for a number of long weekends. By the same token trying to get a number of general practitioners to a two-hour meeting every week would be very difficult and a long weekend would be more appropriate and easier to manage. Therefore provided the fundamental concept of participation is met, the variations will be as diverse as the research topics and the unique participants in the research (Heron, 1996).

Critical subjectivity and intersubjectivity

The successful usefulness of participatory research devolves from and evolves around the paired concepts of critical subjectivity and critical intersubjectivity. Critical subjectivity is the ability of the researcher to take notice of the research with a critical gaze in order to allow a full-unfettered exploration of the project. In Heron's words the researcher/s should be "their own well-honed instrument of inquiry" (Heron, 1996, p. 98). The paired concept to this is the ability of the co-researchers and the co-subjects to be critical of each other's subjectivity, a process of critical intersubjectivity. Without a careful monitoring of the problems of subjectivity from all the participants, co-researchers and co-subjects, there is a potential problem that there will be an undermining of the research and the validity of the research could be threatened. The concepts of "critical subjectivity enhanced by critical intersubjectivity" (Heron & Reason, 1997, p. 8) are woven throughout the discussions on the methodology and are fundamental to validity processes.

In the discussion on validity processes the importance of critical subjectivity is given added impetus by the use of a negative approach. Heron issues a challenge to "uncritical subjectivity" in the research process and identifies three areas that can generate problems of being uncritical. These are firstly a prior commitment to the idea, secondly living the experience, and thirdly believing in it in order to become experientially involved in the process. These can all lead to an inability to notice the "inadequacies" in the research. This can take various forms such as an opposition to change, seeing it from another angle, not noticing the "shortcomings" or taking note of "corrective content of experience". There is emphasis that it is a collective and individual task not to become uncritical and that as the inquirers move into the various domains of knowledge, particularly when it is experiential, it becomes a "tricky business" (Heron, 1996, p. 146). Maintaining critical subjectivity by being

involved in the process of intersubjectivity, in a team, is important and obviously has pitfalls.

REFLECTION

I suddenly thought about the Biblical injunction about noting a mote in someone's eye and not being able to detect the beam in your own eye, in the 'old' King James translation. The following is from a modern translation and it encapsulates the essence of critical subjectivity as well as the problems that the inquirers need to be aware of.

> It's easy to see a smudge on your neighbor's face and be oblivious to the sneer on your own. Do you have the nerve to say, 'Let me wash your face for you.' when your own face is distorted in contempt? (Peterson, 2002, p. 1756).

Yes, critical subjectivity is, in Heron's words, 'tricky'.

The notion of critical subjectivity and its place in research is only briefly mentioned, yet it addresses a problem that could be inherent in *all* research (Heron, 1996). In the quantitative area of research, whatever methodology is used, the researcher is able to stand back and remain a totally objective part of the process. The simple counting/measuring/weighing of data whether they are potatoes or monitoring of the growth of a new strain of sorghum is 'easy' as the subject is inanimate. However as soon as the 'person' enters the research it becomes less and less objective. The *Care* research provides examples in which the patient uses a system of cards, Care-Q, to generate quantitative data (Lea, Watson, & Dreary, 1998). While this may also be 'easy' on the surface, simply asking the who, why, what and how of the questions on the cards raises problems regarding the objectivity of the process.

In qualitative research, theoretically the researcher remains relatively objective in that they are not a 'part' of the concept being investigated. The way the researcher remains objective, in for instance the collection of stories, is monitored as in the transcribed manuscripts are returned to the patients or nurses for verification, the questioning process is objectively structured and there is a distancing from the subject. Hypothetically, the researcher remains aloof, a distant observer in order to

be objective and unbiased. A colleague is busy with phenomenological research and her passion is admirable but, I wonder how critically objective she is.

Objectivity is a given concept in qualitative as well as quantitative research. This objectivity is important and the research process itself relatively controls it. In the case of participatory research the checks and balances are not so easy. Thus the over-riding concept of critical subjectivity and intersubjectivity is central.

In summary, the researcher and co-researcher (in this research the GRN and the small group of experts) set a standard of being constantly on the alert not to make personal assumptions or allow their own biases to intrude into or in the research process. It is not an easy standard to set. There is a need for critical *subjectivity and intersubjectivity,* to be involved and at the same time to be, as Heron suggests, 'unattached'.

Research cycling

The third principle is 'research cycling' (inquiry cycle) and is composed of at least four stages which, when complete, are repeated until a solution is reached. Although each stage is described as being a complete entity there is fluidity in the process so that the cycles are not always distinct. There is no one pre-stated moment or stage where it can be said that the data collection is complete and is ready for analysis (as it is with almost all research both qualitative and quantitative). There is an ongoing cycle of reflection, data collection, and data reflection until the problem is solved or the need is met (Heron, 1996, pp. 73-108).

The practice of participation is an evolving one using the 'research cycles' with the participants. Thus the research question is solved as the group works through issues and give the project a unique identity through the distinctive personalities of the participants.

Resolution is reached when there is consensus, as the question is taken through as many cycles as are necessary to have well founded outcomes. The process should also encompass as "many group members as possible, with as much individual diversity and collective unity of approach as possible" (Heron, 1996, p. 50).

Conclusion

Reason, in a personal communication with Bray, sums up the focus of participatory research. It is about the development of

> knowledge in field settings as a catalyst for change - personal change, organisational change, and large scale social change. Producing change is an important test of the validity of the knowledge derived through collaborative inquiry (Bray et al., 2000, p. 3).

In any research, the 'test of the validity' is essential, but for this research it was important that the results also serve as a 'catalyst for change'. I wanted the research to make a difference. In addition to this personal factor it is important that the research methodology match the aims of the research and the questions being asked are not forced into a particular paradigm or even the method simply to satisfy the whims of a researcher.

The holistic approach of the Fifth Paradigm with an ontology expressed as the subjective-objective nature of mind-shaped reality does justice to the realities and complexities of research in a hospital environment that is at the same time familiar to the nurse and threateningly strange to the patient. This ontology is expressed in participatory research, a collaborative effort where there is a critical awareness of the researchers as they seek the answers to questions and at the same time accepting the evolving nature of knowledge. This is also closely related to Watson's assertion referred to above that the ontology of nursing is relational; more than enough reason for choosing a methodology that is in concert with nursing. The plethora of research on *Care* indicated that it would not be easy to find the answers to the enactment of *Care* that would form the basis for the framework of *Care*, thus articulating this foundational concept in nursing.

In considering the paradigm for this research a number of factors needed to be borne in mind. The intrusion of a researcher into the private world of nurse and patient could change the dynamics of *Care*, a single researcher can become uncritical, co-researchers can influence each other, and a static research process would not allow for any diversions. All these pointed to the fact that a special methodology was needed. Participatory research fits in with the dynamic nature of nursing practice. The emphasis on the primacy of the practical is in accord with the doing of nursing and also allows for the experiential knowing that forms the basis of *Care*.

Chapter 4: Design and Method

Introduction

The Participatory Paradigm, with an ontology and epistemology that is congruent with the notion of Caring as a humanistic quality provides a philosophical framework for this research. Heron (1996) had been using this type of research since 1968/69 and in 1977, and at an international sociology conference, it was named '*vivencia'* a new methodology in research. Participatory research was explicated by Denzin and Lincoln (2000) as a separate entity calling it the Fifth Paradigm. By the time the Fifth Paradigm was incorporated into the qualitative research paradigm as an entity, there was already a burgeoning body of writing on the subject (Borda, 2001; Denzin & Lincoln, 2000). Much of this writing, notes Kasl (2000) in her Foreword to Bray et al's (2000) text, was esoteric and sometimes difficult to follow.

The design for this research has been taken from a practical approach to the participatory paradigm, Collaborative Inquiry (CI), as proposed and explicated by Bray et al. (2000). These authors were 'intrigued' with the participative methodology that incorporated "democratic values and the fostering of both transformative learning and valid, useful knowledge" (Bray et al., 2000, p. 5). This practical interpretation of Heron's detailed work on research in the participative paradigm is based on the values of collaboration and participation, an openness to allow further enquiry into the question, and the production of valid useful knowledge, which will generate transformative learning (Heron, 1996).

This research has been divided into three phases. Each phase includes a number of evolving episodes to maintain a logical sequence. In keeping with the principles of CI the process is cyclical, fluid, dynamic and ongoing.

Phase I addressed the primary question. A group of graduate registered nurses (GRN) reflected on the 'caring' enactments that they had seen or been involved in over a period of three weeks. The reflections were analysed and interpreted in order to elicit recurring actions that indicated *Care*. The results were then discussed by a self-selected group of GRN.

Phase II, dealt with the second question and involved the development of a conceptual framework for teaching a practical *Care*. The results from Phase I, the *Care* enactments evidenced in the GRN reflections formed the basis for the framework. It also included a discussion/meeting with experts in nursing and

education. This was followed by an excursion into the education literature and the available nursing research on strategies used in teaching *Care*.

Phase III involved reflection-on-reflection or what Bray et al (2000) term a higher level of reflexivity (p. 76). As a result of the insights gained and the evolving nature of CI there was a return to Phase I and Phase II and this involved a process of reflection-on-reflection and reflective thinking. As a result there were emergent meanings that were used in a modification of the original framework and a redefining of *Care*.

Research Questions

- What are the specific enactments/strategies/skills that are used to demonstrate *Care*?

The first question seeks to find out how *Care* is enacted in the everyday lives of RN in busy hospitals. Hospital care has for some time been dominated by technology and the dollar. Asserting that nursing *is* Caring is a tautology but is affirmed by much of the nursing literature. Patients, generally in a compromised situation, expect to have competent nursing care as well as *Care* (however they interpret it). Their time in hospital is significant when, irrespective of the health care outcome, they are challenged by a change in their health. Practically, *Care* helps patients meet the challenge. Definitions of *Care* vary and whether the approach is practical or philosophical there is need for nurses to *Care* and this leads to the secondary question that asks,

- How can the findings of this research and the literature be synthesized into a framework for teaching *Care* strategies?

There is a presumption, that, for the most part, only inherently Caring students enter undergraduate nursing programs. Thus the Caring values of students (to life in general) would simply need to be transposed into specific nursing skills to show *Care*. This is not the case, and therefore an extension of the primary question into the quest for a conceptual framework to teach *Care* is necessary. If the contention is true that teaching values is difficult, then the teaching of specific nursing skills that indicate a *Care* will be much easier. A merging of *Care* skills and the *Care* encounter will mean the patient perceives the care to be *Care*. The average length of stay in hospital has lessened to the extent that often RN will only care for a patient

for a single shift and the contact with a single patient is cursory. The need for a *Care* encounter becomes singularly important.

REFLECTION

> My question was clear. What do people do to enact caring? I struggled to come to terms with the 'words' that I was going to use in the instructions to the participant researchers. 'Do' seemed prosaic and words such as 'show' 'perform' or even 'demonstrate' may elicit responses that focused on the psycho-social side and then the reflections would have been focused on the 'touchy-feely'. Even if I underlined the 'do' it might not be interpreted as I clearly had it in my own mind. I specifically wanted to know if there was anything that was consistently done to show caring. The caring research suggested that there were caring acts such as 'touch' and 'communication'. If my research showed this I would have been satisfied, and lecturers would be emboldened to teach such *Care* strategies and would clearly need a framework to structure their teaching. I needed to know what was being done in the busy Twenty-first Century health-care system. After much thought I came up with the word, 'enact'. The word had for me connotations of doing something that was more than simply a task or procedure. I later found as I read and analysed the reflections that the choice had been a good one. The GRN had noticed the distinction.

Design: Collaborative Inquiry

Collaborative Inquiry is defined as a "process consisting of repeated episodes of reflection and action through which a group of peers strives to answer a question of importance to them" (Bray et al., 2000, p. 6). The research process is thus a progressive evolving inquiry in which participation and democracy of the participants is central. A question of mutual interest is explored as the group searches for answers to their questions.

The process was modified in that there were two groups of experts/peers that addressed the two different but inter-related questions. The reasons for this were two-fold and are related to the first two phases of the design. In the first phase it was

important to observe and then reflect on the *Care* strategies of the RN in as wide a variety of settings as possible and in as natural an environment (without having a structure imposed on the research process) as possible. This would be done by the GRN reflecting on *Care* enactments during the first three weeks of their professional lives. It was a learning process for themselves as well as contributing to the research process. This group, the GRN, is dealt with in more detail later in this chapter. In Phase II the experts were peers and were able to participate in the process at a level at which the GRN could not participate. The experts were peers in teaching, and could participate in a dialogue about teaching that the GRN could not. The critical cyclical reflective elements of the design remained true to the CI process.

The perspective is holistic in which all partners in the process are of equal worth and self-directive in the operation while maintaining a dialogue with each other. Central to the process is the search for a mechanism/catalyst for change (Bray et al., 2000, pp. 1-15). The process is dynamic because methods are developed and redeveloped to focus more clearly on exploring/answering the question.

The adjectives that Bray et al (2000) use in the discussion on the importance of the research question in CI are both interesting and challenging. Interesting, in that the adjectives are forceful and used repeatedly, such as significant and compelling. The adjectives are also challenging, in that the authors suggest that questions should be ones that have not been satisfactorily answered. The questions about *Care* reflect the nuances of the above statements on questions within Collaborative Inquiry. The importance of *Care* is significant, how *Care* is enacted is compelling yet there seems to be confusion and contradiction as to how *Care* is practically shown in the reality of the clinical world.

The implication is that in CI the question assumes a greater importance (than in other research) because it originated in the real world and thus bridges the theory/practice gap. The importance of collaboration as a method of inquiry and the need to address the questions that "confront people in their daily lives", which enable them to learn through their experience, are fundamental to the methodology (Bray et al., 2000, p. 27). A further extension is that once learning has taken place, in an ideal world, changes should be made and again ideally these changes should be for (in Heron's terminology) human flourishing.

The design for this research is a CI design which draws on the fact that CI is an "imaginative and a holistic approach to human inquiry" (Bray et al., 2000, p.1).

Underpinning this design are the four concepts of CI – it is evolving, it is participatory, there are episodes of reflection and finally, validity must be checked. These four key concepts will be discussed here.

CI is an evolving process: flexible and cyclical

'Process' is at the heart of the way in which CI is conducted. At first glance it is simply a synonym for other words such as procedure, course of action, route or even method. These synonyms have prescriptive aspects that do not reflect the essence of how the design should be applied. 'Process' in CI reflects a flexible cyclical flow of consideration, interaction and a shared journey for the participants.

The word "process" is used extensively in the text and at times it seems as if it is used in place of research. In view of the fact that the word research is semantically linked to the notion of the researcher (as being the dominant force in the inquiry), it seems that the writers are reluctant to use this word. Thus the use of the word process is congruent with the philosophy of the participatory paradigm in that the researchers are all equal participants. The word process is also linked with the words inquiry as in 'inquiry process', and collaborative as in 'collaborative process', and with the concept of the 'meaning-making process' indicating the inclusiveness of the participants and the holistic nature of the method (Bray et al., 2000, p. 6).

The point is made emphatically that the method itself is flexible, without too many constraints, that there is "no dogmatic way to conduct a cooperative inquiry" and that the researchers and the participants are free (within the constraints of the question) to follow new leads and new directions as the data unfolds (Bray et al., 2000, p. 5). The process is dynamic. The flexibility is however constrained by the fact that it is cyclical and evolving in nature. The evolving nature is such that there is a time span between the episodes of investigation. This is to allow for the thought processes to percolate and re-order so that the next episode/phase is built on the previous one in a meaning making process. It is not a haphazard process. The parameters of the design for this research were set in the three phases but they allowed for flexibility within the phases, and in the evolving episodes. These episodes were planned but also evolved with the ongoing reading and input from the participants.

Participants and peers

There were two sets of groups who would join the research process. The participant researchers, a group of newly graduated students, the Graduate registered nurses (GRN), who would be reflecting on how *Care* was enacted. The second group, the experts, would be advising in a later phase to critique and evaluate the conceptual framework as it was being developed. As in the above reference to the flexible use of the word 'process', the words "participant" and "peer" are also used interchangeably.

There are two aspects that are inherent in the CI interpretation of peer. The first is that peer is given equal value and status. The second is that there is diversity in the group. There is an anomaly here that is not clarified. At times the researchers as a group are in fact distinct from the researched. In other words there is an indistinct difference between 'participants' and 'peers'. Herein lies the significance of CI – depending on the research question (and diverse examples are given) there are different interpretations of the role of the participants and peers. In spite of this equality value, a particular group of researchers with diverse backgrounds and different skills, experiences, and communication and learning styles enrich not only each other but also the depth of the research. The value of having "commonalities and divergence" assists the group in bringing a different perspective and breadth of prior knowledge to the inquiry process (Bray et al., 2000, p. 59).

Although the physical context is discussed in terms of the meeting place of a collaborative group, 'the 'genius loci'- the spirit of the place' also applies to the data collection place. Bray et al use the words 'history' and 'values' in relation to the 'genius loci' (Bray et al., 2000, p. 57), and although the hospitals would have their own history and values, nursing research needs to be done where the 'genius loci' of nursing resides, at the bedside. In this research the setting is the hospital, the ordinary wards of private/public/rural/city hospitals where the everyday nursing care is given. While it could be argued that the loci will be different, the 'genius', the spirit of nursing itself, will ensure that the ordinariness of nursing (Taylor, 1994) is portrayed 'behind the screens' (Lawler, 1991) or perhaps, as some might cynically say, as it really is. The participation at this level would in part bridge the theory-practice gap.

The participant/peer and context are both closely related to authenticity issues. In Phase I the focus and emphasis is on the participant, the participant/peer

researchers, Graduate Registered Nurses (GRN) who would be engaged in clinical nursing. The GRN were observing and reflecting on their own Caring and knowledge of Caring and how *Care* was being enacted. There would be no intrusion of a researcher or formal research process. It was in effect a research process to 'tell it as it really is'. The informal structure of the research process would allow an authenticity in both the place and the person when generating the data.

In Phase II the emphasis is on the peer, the peer participant researchers were experts from nursing as well as from education, thus there was a balance in the diversity of experts. The diversity is seen not only as an asset but also a necessity, adding richness to the research (Bray et al., 2000, p. 59). Heron (1996) is very clear about the impact and necessity of having participation in qualitative research indicating that "the more fully researchers participate in the cultures they are studying, the more it shifts into the direction of co-operative inquiry" (p. 27).

Finally when there is a group of people (researchers) working together, it is only an idealist who would venture to suggest that the path of inquiry would be without tension. The advocates of the method contend that the fundamental premise is that there can be differences in what participants of the collaborative group believe in "as long as they agree to the essentials" (Bray et al., 2000, p. 6). The essentials are that, firstly, there is a need for the researchers to have an authenticity in the reflections (their motivations need to be sincere), secondly, there should be a democracy (with guidelines) in the way that they operate, and lastly there is a commitment to a "holistic perspective on the construction of valid knowledge" (Bray et al., 2000, p. 6).

Repeated episodes of reflection and analysis

Bray et al (2000), in the discussion on reflection and action in lived experience, describe the episodes/cycles as being at the heart of CI, a "powerful approach to learning" and a tool for inquiring into the "nature of human experience" (p. 10). The ways in which the episodes of reflection and action are conducted are open to an ebb and flow process that is congruent with the findings and the determinations of the way in which a particular CI research group operates. What is of importance to this research is that it is a method that is able to probe into the heart of experiences at both an experiential level and an expressive level. It is within the cycles of reflection that the 'process' discussed above is exemplified. The

cycles/episodes of reflection (and action) occurred on a number of levels. The first level reflections came from the GRN, followed by the focussed reflexive intention of the researcher during the literature review and while interpreting the reflections. At yet another level the reflections from the expert group were incorporated into a reflexive episode as the data was revisited and exploratory reading done in the educational literature in the light of their comments.

Reflection is a core concept within CI. Inherent in the concept of reflection is the fundamental notion that the participants in the research are participating on a personal level. It thus follows that reflexivity is also a predetermined concept. Reference is also made to the researcher who should utilise all their 'sensibilities' (Bray et al., 2000). This and other references, such as 'authentically' embracing the values of generating 'useful knowledge' of the researcher (me), give a clear indication that the notion of reflexivity is of importance. Intrinsically, within the concept of reflection, is the fact that the self is acknowledged.

Checking validity

Validity in CI involves two distinct processes. The first process is that of identifying threats to validity. These include threats such as 'defensive routines' and 'groupthink' with the participants, or group dynamics if there is a group that is meeting to identify and deal with problems (Bray et al., 2000, p. 105). In this research there were only two meetings, one with each small group. As these were only single encounters with the participants, neither of the above threats was considered to be a problem.

The second and more important process is that of ensuring that ways are found to check the validity of the findings. CI is able to do this during the cycles of reflection and action and using the cycles of convergence and divergence. It is, as it were, a 'method triangulation, by comparing different sources of documentation.' It is a process where experience from at least three people is used to check validity, the process being called "phenomenology-in-several-voices" (Bray et al., 2000, p. 109).

A further validity check is where it is possible (or necessary) to share the information with "informed outsiders who can play the devil's advocates" (Bray et al., 2000, p. 109). This occurred in Phase II in the meeting with the expert group. Bray et al (2000) further discuss Lincoln and Guba's authenticity criteria of fairness and catalytic, ontological and educative authenticity. However they point out that

this is most useful in circumstances where there are problems with the participants failing to agree, and that when this does not happen, then the experience is allowed to speak for itself (Bray et al., 2000). This was not a problem in this research. The concepts of critical subjectivity and intersubjectivity together with aspects of reflection discussed in detail by Heron (1996) are not dealt with fully by Bray et al (2000).

Method: a three phase cyclical process

A three-phase method was developed as indicated in Figure 4.1. Each phase consists of a number of evolving episodes. Although these are 'sequential' they have not been numbered as this indicates separate sections and the inter-relatedness of the research process is visually lost. This is in keeping with the evolving nature of CI. The word process has been used deliberately. Process, as discussed earlier, is the modus operandi of CI – the research itself. The process will be described using the above three phases as a structure for describing the procedures that were followed.

Participants play a crucial role in this research. There were two groups, the main group of researchers in Phase I who reflected on the *Care* enactments/strategies/skills of RN. As the Graduate Registered Nurses (GRN) played a key role in this research, some detail will be given regarding their recruitment.

The second group who reviewed the conceptual teaching framework, (the PPCar* - Professional Personalised Caring in Nursing), were part of Phase II and as the group was smaller the choice less complex. Therefore the detail regarding this group is less.

Figure 4.1 A three phase cyclical process

Phase I – How is *Care* enacted? – the GRN reflections

Participants	Evolving Episodes
The GRN group	*Reflections on caring enactments*
Researcher	*Analysis and interpretation of reflections*
Six GRN meet	*Dialogue on enactment analysis*

Phase II – A framework for teaching? – the experts

Participants	Evolving Episodes
Researcher	*Integration of related literature and the interpretations from the reflections resulting in the PPCar* framework*
The expert group	*Discussion of proposed framework – PPCar**
Researcher	*A return to education literature*

Phase III – Reflection-on-reflection – the researcher

Participant	Evolving Episodes
Researcher	Reflection-on-reflection on Phase I and Phase II
Researcher	Re-constructing meanings

Phase I – How is *Care* enacted? – the GRN reflections

Phase I incorporates the selection of the participant researchers (the GRN), the collection, analysis and interpretation of the reflections and the Dialogue Day in which six GRN participated in a discussion of the collated/interpreted reflections.

The GRN group – Participant researchers

It could almost be rightly argued that this was a convenience sample. Nonetheless the circumstances regarding the choice of participants are unusual. I had been involved in the teaching and mentoring of the class of 2001 over a period of three years, unusual in my department of nursing. The GRN group in the research would provide a solid foundation for the process. "The more the participants

appreciate each other as people beyond their role as group members, the better the inquiry" (Bray et al., 2000, p. 111). I had simply asked the group in the last tutorial of the year to leave their names and addresses on a table if they were interested in taking part in my research. The response proved that there were a considerable number who were interested in participating. The comment by Bray et al (2000) above was being brought to life for me.

I considered other important aspects of the GRN Group. There were commonalities and divergences in the group, as well as an authenticity that I was certain that I would not find in other groups who did not know me well, and finally the context of their reflections would be ideal. These factors will be briefly discussed.

There were commonalities and divergences in the group. The commonalities were obvious. The curriculum for the Bachelor of Nursing has a solid foundation of *Care*. All students were required to take a unit/course that is devoted to the concept of *Care*, and in addition there are lecturers who have a total commitment to *Care* and incorporate the concept into their teaching. The graduating group would all have had a common understanding of *Care*.

A further factor in the suitability of the group is that they had all had been involved in the writing of reflections. There are two units/courses in the program that use reflection as part of the assessment. In addition, they had all completed a research unit/course and so had a common understanding of qualitative research. All the participants entered the workforce at the beginning of the year.

For all the commonalities, the Class of 1999 was also divergent. The group was typical of the groups that enter nursing programs. They have mature age students, students with a wide range of academic ability, 10 – 12 % males and a number of students with previous nursing experience. It may be argued that some of the participants had previous nursing experience but these experiences were also diverse and their role as new graduates would be significantly different to that of an assistant in nursing or an enrolled nurse. The new RN, no matter what the previous nursing experience, would view the caring in nursing from a new perspective in a wide range of health care agencies.

The context of the *Care* was also foundational to the research. I wanted to explore *Care* in the real world without the formal structures of research. There would be no pressure for anyone to *Care*, nor were any people being directly

observed. The instructions clearly asked how people enacted 'caring'. It should however be noted that in a box a series of questions asked about the RN and the way this group showed *Care*. The *actions related to Care* were simply being reflected on. The GRN were exploring *Care* in the real world of nursing, whatever the real world was to them at that point of time. They were meeting and caring for patients with nursing personnel on a daily basis. There was no limitation put onto the place of practice. I simply wanted to know what was being done to show patients that nurses still *Care*. A variety of hospitals in rural and city settings ensured that the *Care* as a universal nursing phenomenon would be studied without regard as to the placement of the research. *Care* enactments were the focus, not the speciality or the geographical location.

My intuitive reaction was that the Class of 1999 would be authentic in their reflections. Why? This was an end result of the relationship that I had built up over time with them. It is in this respect only that the GRN group could be considered a convenience sample. The students that had indicated an interest in participating had done it out of a real interest. Agreeing to participate had been done freely and without coercion.

There were two factors that were taken into consideration in relation to the timing of the participatory reflections. In the first instance, the less rushed 'orientation period' would be an ideal opportunity to observe and reflect on the *Care* enactments. In the second instance, the newness and enthusiasm of the GRN would give the observations and reflections a fresh unbiased approach that would add strength to the research. In essence the caring enactments would have been viewed with 'new' eyes from the 'same' theoretical perspective.

The Process

The recruitment process took place at the end of Semester II 2001. See copies of the letters and information package labelled Phase I in Appendix 1. The group were sent material on four occasions.

The Initial Letters

The list of interested 'students' was carefully reviewed and the group of non-graduating students were sent Letter 1. Letter 2 was sent to the group of graduating students.

The Reflections Package

The guidelines for the reflections were sent out in mid-February 2002. The starting date of the graduate nurse programs varied. It was not possible to send out the research instructions to coincide with the starting date of all prospective participants. The Reflections Package was sent to the 46 prospective participants who had graduated.

The package contained:

- Letter
- Instructions on how to send in the reflections.
- A guide to Reflecting.
- Envelopes (3) – These were stamped and addressed to my home address.
- Notepad for reflection notes.

Some of the detail relevant to the research process is given below.

Instructions

The research requirements specifically asked for a caring incident that reflected the way that "caring was enacted". Three reflections on how caring was enacted were asked for. The task was to identify what people 'did' to **enact** caring or as also indicated in the instructions 'how is it done?'. In order to clarify what the GRN meant the instructions asked for a specific incident to clarify the action. It was indicated that length was 'immaterial'. (Note: When the letters were sent out the decision to differentiate the various meanings of 'care' had not been made, therefore *Care* as Caring in nursing was not in italics.)

Two strategies were used to ensure that the reflections focused on the requirements for this research. The first was a single page on the process of reflecting and the second an inset box on the instruction sheet. This small inset box with eight questions was included to 'get you thinking', and were in fact a re-phrasing of the research question. The questions were a strategy to focus the GRN

on the task of identifying caring enactments. 'How is this caring portrayed?' 'What actions would you copy?' and the longest one, 'Are there special techniques these caring RN use which distinguish them as caring?' They were used in order to emphasize the need to focus on a '**doing**'

Reflections

A single page on the value of reflecting was intended to serve as a reminder of what reflections were and how to use reflecting as a tool. Although the incidents of caring enactments were the focus for this research, the reflections were perceived to be part of their orientation to nursing and serve as a useful function in bridging the gap between university and the clinical world.

Any GRN who later decided that they did not want to participate simply did not send in any reflections.

Reminder

Four weeks after the mailing of the reflections package a reminder was sent out.

Invitation to the Dialogue Day

After a further four weeks the invitation to the Dialogue day were mailed

Record keeping

Records were kept of reflections received: date of arrival, assigned GRN number, the reflection number and whether the reflection had come from a rural or city hospital. All this information could be gathered from the information on the back of the envelope. This enabled the assistant to keep track of the participants and how many reflections they sent in. Each reflection was labeled using the same coding system that had been used when the instruction package was sent out.

The responses were transcribed by an assistant, and checked for accuracy by a second assistant. Spelling and grammatical errors were not altered. All responses were transcribed into a single document in two formats. The first simply labeled the reflections from 1-64 (see Chapter 5) and the second gave the coded GRN number and the reflections were labeled 1, 2 or 3. The transcripts were then transferred into

the Nvivo computer program. Nvivo, a software program, would later be used to identify themes and keep track of the transcribed GRN reflections.

Factors that increased the response

I was conscious of two factors, external to the study, when sending out the material. The first was that the GRN had recently completed a unit of study in research, and so they would be critical of what I sent them. They would know the 'correctness' of the material; I was the 'student'. The second factor was that I needed to role model my stand on excellence. Wording, grammar, format were checked and rechecked. The paper that was used was 'different' and return envelopes were stamped (and not franked).

The Dialogue Day

The concept of a dialogue day was generated by Fitzgerald's and van Hooft's (2000) description of a Socratic Dialogue on love in nursing. The Socratic Dialogue, in their research extended over some hours where researcher and participants meet informally in a relaxed setting (over a meal) to tease out an issue/concept and attempt to arrive at some consensus. (Fitzgerald & van Hooft, 2000) Regular meetings were not feasible as the group were scattered over a wide area and shift work precluded meeting on a recurrent basis. A full day was a satisfactory alternative.

The concepts of participation in CI and the cyclical dynamic nature meant that the inclusion of a dialogue at some stage would add to the validity of the research. The Dialogue Day was three or four months after the reflections had been sent in, recent enough not to diminish the impact of the written reflections and yet sufficiently removed from the initial orientation period for the participants to have a value perspective on the research. There would be time for socialising and it was important that the group be able to meet in a relaxed atmosphere. "Time-outs allow for reflection on the process and give space for people to articulate 'where they are' in the process." and "Time spent socialising apart from the inquiry contributes to fuller participation within the inquiry." (Bray et al., 2000, p. 111) The Dialogue Day was held at 'Glenrae', our home, the setting was relaxed (good food and a warm fire.) and the venue removed any formalities that would hinder the dialogue process.

There were six responses to the invitation to attend the Dialogue Day. A Dialogue package was sent to the six GRN who had replied in the affirmative. The package contained the following:

- Letter.
- A brief summary of the initial analysis of the reflections.
- Directions to our home.

The participatory dialogue was held in June 2002. The six GRN attended together with my primary supervisor and an assistant who taped the discussions and took notes. The mix of the six GRN participants reflected the mix of the group who had sent in reflections. Only two of the participants had remained in contact since registration and there was a sense of camaraderie even though there were some who had not met. Their age, hospital and ward environments were diverse, and there was one male.

A copy of the transcribed reflections was given to each GRN when they arrived and these were perused during the first hour. These were collected prior to the participants leaving.

Permission to tape the discussion was granted. The tape was transcribed with the help of the hand written notes. A copy of the transcript was sent to each of the participants for verification, together with a letter asking if the GRN had any further reflections that they felt were important to the research. There were two responses to this question.

The analysis and interpretation of the reflections is dealt with in detail in Chapter 5.

Phase II – A framework for teaching? – the experts

Phase II incorporates the creation of the conceptual framework, the selection of and meeting with the expert panel and a return to and further exploration of the literature in education as well as in nursing.

The conceptual teaching framework

The analyses and the interpretations of the reflections as well as the *Care* and Caring literature were used to develop a conceptual teaching framework, the Professional Personalised Car* (PPCar*). The intention was to use this framework to teach *Care* to undergraduate students in nursing programs. It was not surprising

that the actions had already been identified in the *Care* literature. The literature on Caring gave a broader dimension to the enactments identified by the GRN group. In Heron's (1996) terms the development of this knowledge is propositional knowledge.

The Expert group – participant researchers

The notion of an expert panel is not specifically included in Bray et al's (2000) explanation and elucidation of Heron's (1996) participatory research. There are however enough references to the importance of diversity and the inclusion of experts to justify using an expert panel in this research. Collaborative Inquiry is by definition not Action Research as the emphasis is on collaboration, and the group in this instance was not the subject of the research. The breadth of experience of the experts would 'add to the richness' of the inquiry (Bray et al., 2000, p. 59).

The four experts were from education and nursing. The lecturers from education each had their own area of expertise. The first has an interest in teaching values and had for many years taught a unit/course in the eduction faculty on teaching morals to the primary school pupil. The second lecturer had a PhD in theology and an interest in teaching values. He had taught in the education faculty for some 25 years. One of the experts in nursing was from the clinical area and the other, who had taught for more than ten years, was from the university sector. The experts were first verbally requested to become part of the panel and, having given their approval, a written invitation was sent. (Information package labelled Phase II are in Appendix 2)

The invitation included details of the proposed framework on *Care*. The comprehensive information was necessary to allow time for the experts to reflect on the framework in keeping with CI. The discussion was scheduled at a time convenient to all those concerned and was held in the boardroom of the science faculty. At the last minute one of the experts in education had to withdraw as personal reasons prevented him from attending.

The discussion was taped with the permission of all participants. A research assistant took notes and two of the experts who had made notes on the sent material graciously gave me their notes at the end of the discussion.

A new focus in the literature

Advice from the expert group to focus on the education literature was taken and literature on curricula, objective setting and the teaching of values was explored. The literature on the teaching of *Care* was revisited. Phase II is dealt with in Chapter 6.

Phase III – Reflection-on-reflection – the researcher

The cyclical nature of this research process meant that there was a movement from the previous two phases into Phase III, and a re-thinking of the insights gained from Phase I and Phase II. This is in keeping with the methodology of cyclical reflexive phases that repeat the circuits and move to a new and richer appreciation of the question being explored. Bray et al (2000) call it reflection-on-reflection or a higher level of reflexivity (p. 76) as well as "making meaning" (p. 14). It is a process where a deeper level of questioning occurs. There was a return to the GRN reflections, a re-examining of the literature and a possible reconfiguration of the teaching framework. Chapter 7 contains these developments.

Ethics

Ethical clearance from the University Ethics Committee was granted. The research instructions clearly stated the ethical guidelines and that there was no coercion to participate. The GRN would simply not respond if they did not wish to participate. A response was an acknowledgement of the ethical guidelines and that the ethical guidelines were understood and would be followed.

Chapter 5: Phase I – How is *Care* Enacted?

Chapter 5 addresses the first research question:

- What are the specific enactments/strategies/skills that are used to demonstrate *Care*?

The evolving episodes in Phase I incorporated the analysis of the reflections from the GRN, the interpretation of the analytical results, the reflection and exploration of the literature by the researcher, and finally, a dialogue day with six of the GRN.

The principle participant researchers were the GRN as they reflected on Caring enactments in a variety of busy hospital wards. The wards, hospitals, RN and patients were lost in the anonymity of the incidents in the reflections of the GRN who were only identified by a research number. The incidents on which they reflected were neither unusual nor simply anecdotes; they were living scenarios played out in the daily routine of RN and patients. The incidents were similar to those I had experienced as a RN and that I and others had shared over the years. Yet they were as unique as the individuality of the persons involved and the way in which the incidents were played out. Quotations from the reflections are in Arial font followed by 'GRN' and the research number allocated to each graduate registered nurse.

This chapter deals with Phase I of a three phase cyclical process. Figure 5.1 shows all three phases. The second and third phases, which are discussed in Chapters 6 and 7, are printed in a lighter tone.

Figure 5.1 A three phase cyclical process

Phase I – How is Care enacted? – the GRN reflections

Participants	***Evolving Episodes***
The GRN group	Reflections on *Care* enactments
Researcher	Analysis and interpretation of reflections
Six GRN meet	Dialogue on enactment analysis

Phase II – A framework for teaching? – the experts

Participants	***Evolving Episodes***
Researcher	Integration of related literature and the interpretations from the reflections resulting in the PPCar* framework
The expert group	Discussion of proposed framework – PPCar*
Researcher	A return to education literature

Phase III – Reflection-on-reflection – the researcher

Participant	**Evolving Episodes**
Researcher	Reflection-on-reflection on Phase I and Phase II
Researcher	Re-constructing meanings

Introduction

The first section of Chapter 5 deals with the numerical counting of the *Care* enactments. While *Care* can never be reduced to numbers, the frequency of the enactments of *Care*, as perceived by the GRN, were valid indications of the ways that RN showed Caring to their patients. Three themes or clusters of data were identified and interpreted in the light of the literature and the reflexivity of the researcher. The first cluster, the GRN Voice, describes the GRN as they entered the workforce and reflected on *Care* enactments and, in the writing, exposed how they themselves were coping and feeling. The second cluster, the RN, is an interpretation of how the GRN read the RN and their attributes. The third cluster, the *Care* enactments, as identified by the GRN, are dealt with in more detail. Each enactment is dealt with separately, although it must be pointed out that some of the enactments have more detail than others. This is due to the fact that there was either a paucity or lack of specificity in the literature. The first two clusters are dealt with briefly, as they are only superficially related to the first research question. The final episode of Phase I is the Participatory Dialogue which is a simple reporting of the event.

The voice of the GRN was clearly heard in the reflections. The reflections come from the lived experiences of the GRN and are at the heart of this research. The reflections and the incidents were for the GRN a distinctive or special episode and highlighted the way in which the RN (and sometimes the GRN as well) imparted *Care*. Sometimes the reflections reflected the GRN *themselves* and how *they* were coping and at other times there were comments about *Care* as they saw *Care* happening in their new environment. At other times the *RN themselves* were discussed or given prominence. The analysis and interpretation could not omit these important aspects of the GRN reflections. Thus, in addition to the initial objective quantitative analysis of the enactments/strategies/skills, the revealing tangential remarks of the GRN had to be taken into account. The GRN themselves and the *Care* RN, were also addressed.

There is both an explicit analysis as well as an implicit interpretation of the reflections. The explicit analysis is a simple quantification of the data whereas the interpretation seeks the depth and threads of meaning and the links to the literature. The interpretation is cyclical, in keeping with the philosophy and methodology of

this research, and involves reflexivity on the part of the researcher, exploration of the literature and a dialogue with the GRN, the co-researchers.

Some of the GRN told what they themselves had done to give *Care* and there were comments on what they felt *Care* to be in the light of a particular incident. The perceptiveness of the participants regarding their own behavior indicated a reflective maturity coupled with an excitement at achieving their goal of being an RN. Many incidents were short - just a few lines - others were longer. The transcription of the reflections into a standard format gave a sense of uniformity and assisted in an objective analysis.

The GRN were numerically coded when the initial letters were sent out in order to maintain anonymity. A complete set of one GRN reflections is included in the Appendix 4.

The power of the reflections – reflecting the essence of *Care*

The power of the reflections, the raw data, needs to be acknowledged first. The fact that these are reflections, and must in the first instance be taken as a whole, is important. The power of the incidents comes through as they are read. Although the incidents in themselves are not part of the research, due acknowledgement to the incidents must be given.

I would return to the reflections and read them again and again. Sometimes it would seem as if I was reading them for the first time and would have fresh insights into the enactment/strategies/skills, at other times it was as if I was remembering my own nursing practice. The finer nuances and gradations of meaning were in effect not imbedded in 'words' as much as in the incidents and the way in which they were written. The *Care* enactment/strategies/skills were powerful in context and the initial analysis seemed trite. Some of the incidents and reflections bare the soul of the writer and I felt reluctant to add a further meaning to the rich reflection on the day-to-day experiences in *Care*. The incidents gave substance to the enacted *Care*. The ordinariness of the *Care* incidents rang true. The stories flowed as if the GRN was telling them to me in person; it was as if the years of experience filled in the blanks. There were no unusual or different scenarios that I had not experienced myself or had heard colleagues relate. The reflections and the incidents are powerful and often tell more than they 'say'.

Reading the reflections was in the first instance an extraordinary experience. The GRN had been there in the workplace and had taken the time to reflect and record and told me not only what they had seen but also what they had felt. The personality of the individual GRN was apparent. The inner feelings came through clearly even though I was reading typewritten transcripts of these reflections. Much later I viewed the originals and was surprised to see the number that had been hand written. The personal nature of reflections became more real as I viewed the originals. It was as if the GRN were all talking to me personally. They *were* the co-researchers.

Interpreting the data would not be as simple as the counting and the superficial analysis. A metaphor describes the process of interpretation. A post-hole digger on the back of the tractor going deeper into the earth, a giant corkscrew, so that the fence post when dropped into the hole would stand firm and true. Sometimes the post-hole digger hits a rock and a new position has to be found. So too with the interpretations. As I reflected on some of the incidents, new light was shed on *Care*, the implausible interpretations of *Care* research, such as responding to *all* needs of *all* patients, would give way to the reality of understaffing and the high acuity of patients in hospital. The rocky terrain of reality would surface time and again and eventually drive the final interpretation of *Care* in Phase III.

I had cycles of reflection and action. The action was always intense, periods of days at a time of reading and writing. The reflection varied as I took breaks away from the research itself. The 90 km return trip to the university each working day provided ample time as I cogitated, visits to the hospital on faculty business sometimes threw fresh insights into the research, and a longer break on a lecturer exchange overseas brought times when the research was a dim reality in Australia. All served to gain new perspectives and the interpretations became clearer and more meaningful as I became immersed in the data (Roberts & Taylor, 2002).

The power of the story is exemplified by the reflection of GRN 34 who gives an insight into the care that the RN, supported by the RN team, gave to a dying patient. The details of the medications and the hot bath are not exceptional; it is the combination of the place and timing, not just the RN who did the *Care* but also all the other RN on the shift that evening and the impact that it made on GRN 34. The entire incident is given here. The GRN has used ‘Pt’ to indicate patient.

Pt was achy and sore and health that shift was deteriorating quite rapidly. Her nurse had given her every pain relief available and had her doctor who prescribed more pain relief. None of these medications had any effect. The nurse was visibly concerned and openly told other staff that there wasn't much else she could do and felt as though she was letting this pt down. She then drew a hot bath with aromatic oils, turned on an aromatherapy lamp and found some relaxation music. The pt also had her feet massaged by this nurse while the pt relaxed in the bath. On returning to the bed, pt stated her pain had lessened and she fell asleep. While the nurse attended to this pt's bath and tried relaxing the pt the other nurses cared for her pts. The nurses on the ward that evening were concerned and cared for this pt. And as a team they were able to relieve this pts pain but also care for the other pts on the ward. The relief and trepidation they all experienced when the pt was asleep was incomprehensible. One of the nurses later explained to me that it provided the nurses with a sense of fulfilment that they had met their duty as nurses and human beings in caring for this pt. To me, I believe that sentence is very important and that when I nurse people this is what I strive to achieve. GRN 34

The fact that the RN was persistent and took the time to ensure that the patient's pain was relieved, and that the *Care* of the RN colleagues took on an extra patient load, makes the whole incident noteworthy for this GRN. GRN 34 reflects on the incident as being personally special and an incident that has been a learning experience.

Some of the incidents were simply nursing 'cares', but the impact for the GRN was sufficient to document it as a *Care* incident. Here GRN 25, who earlier was critical of non-*Care* RN, finds an RN who gives gentle holistic care and the wider implications for the family are taken into consideration. The honesty of the reflection revealed a dichotomy, the gentleness of the RN contrasted with the powerful impact of the experience on the GRN.

I had a RN ask me to assist her to shift a patient. This little lady was 101 and dying, and we were doing PAC (Sic. pressure area care) every 2 hours. This particular RN whom I took for being rather brisque (sic) was so gentle with this lady, we talked to her as we shifted her, as this was the only time during which she opened her eyes. The RN then rubbed her back with

lotion, an added bonus in this case is that when the family returns to the room the patient smells nice too. There was such gentleness and caring shown towards this dying patient. GRN 25

This is one of the incidents in which gentleness is used. The gentleness on its own is not important but, seen in the light of the apparently frail elderly patient, takes on a special perspective. The counting in the analysis does not take into account the contextual power, and although 'gentleness' was analyzed early as an enactment/strategies/skills, in this incident it assumes greater impact.

There is a lesson for GRN 25 in this instance too, as the reflection is written; a personal aside/note is added,

I am finding it important to me that I come across as a caring RN. I want my patients to feel special and to feel that I am doing for them all that constitutes caring for them and their family. GRN 25

In context GRN 25 almost seems to be apologizing for her previous assessment of the 'brisque' RN and yet has also learnt that the 'brisque'-ness of the RN is a trait that she does not want to have.

Finally there were two aspects of the raw data that needed to be borne in mind. In the first instance it had to be remembered that the real incident had already been interpreted once. In re-interpreting the incidents I had to be careful not to move too far away from the reality as perceived and then expressed by the GRN. The GRN had already reflected on what *Care* was and had made a choice as to what details to relate that were critical to their elucidation of the enactment/strategies/skills. The reflection was in itself a story. For the GRN it was exceptional. It would be important to stay within the parameters of what had been said and not to read too much into the incidents in spite of the power of the story.

In the second instance I needed to be careful not to overshadow the reflections with my background knowledge of the *Care* literature. A disproportionate dilution of their voices by the addition of mine would have made a mockery of their incidents. It was important that the authenticity of the reflections be maintained by not deviating from the context of the incidents. The essences of what the GRN were really saying about *Care* must not be lost in a theoretical explanation.

It could be argued that the GRN were not given any standards to measure whether or not the enactments were *Care*. The GRN recognised the *Care* only as the patient responded to the *Care* enactments of the RN. Even the 'difficult' ones.

How did the GRN recognise *Care*? I did not ask them, I simply assumed that they knew. They all wrote confidently as if they did know. I knew that they had a theoretical base and the practical outworking and recognition of *Care* was up to them. I did not have any misgivings. My confidence in the GRN was justified…they did KNOW.

Counting *Care*

Counting *Care* deals with research reporting requirements and was a simple quantitative analysis of the data. This entailed extraction of phrases/words to elicit the ways that RN enacted *Care* or as one GRN reflected the "practical reality of caring" (GRN 14).

Response rate

Participating, by sending in the reflections, was totally voluntary. There were three points at which the co-researchers could have opted out of the research process. The initial request at my last tutorial with them, the letter informing them they could drop out of the research, and finally the GRN need not have submitted their responses.

There were 24 responses received from the 51 GRN who had indicated an interest in the research, a response rate of 47%. Two GRN sent letters to say that they did not want to participate. One of these indicated that there had been a death in the family resulting in a delayed starting date. A third GRN phoned to apologize that she had not sent in reflections as she had delayed her starting date to midyear and would be happy to send in her reflections then, and one sent in a very late reflection that was not included in the analysis and interpretation. Thus, in all, 28 had contact with me, a 55% response to the formal research package. Twenty-four GRN sent in the first reflection, twenty-one sent in the second reflection and nineteen sent in the third reflection. This gave a total of 64 reflections written at various times.

TABLE 5.1. Summary of Responses

TOTAL N=51	**Reflection 1 Received**	**Reflection 2 Received**	**Reflection 3 Received**	**Sent regrets late start**
N	24	21	19	4
%	47%	41%	37%	8%

No GRN used any names or identifying characteristic of the hospital where they worked. Five GRN identified the area in which they were working such as 'a busy surgical ward' and although a further two did not specifically identify the area, the incidents could be identified as being from theatre and possibly a psychiatric unit. There was space on the addressed return envelope for the GRN to indicate whether the hospital was rural or city. Although this data was recorded there was no reason to use it in the analysis and it was never used.

The reflections as a whole indicated that the participants focused on what was required. There were only 33 A4 single spaced transcribed pages of the reflections. In addition to the fact that the reflections were articulate and perceptive, there was a sense of authenticity. There was a real desire to find out what was going on and an objectiveness and maturity that was surprising in early professionals.

Those GRN who did not reflect on a specific patient-related incident commented on what they had seen *Care* RN do as a normal part of their daily care to patients. There was therefore not always an incident that reflected a single enactment of *Care* because a single incident may well have recorded more than one *Care* enactment/strategies/skills.

Predictably, the *Care* skills of the *Care* literature surfaced, although not as many as I had anticipated. GRN 05 makes an insightful statement. *The same caring actions may not work all the time; different people and situations will change the effect of the caring. GRN 05* This GRN explained this by noting that one *Care* RN sat and had a pizza with the elderly long-stay patients, and another RN dealt differently with a young child and the parents in an Accident and Emergency Department. Perhaps this was stating the obvious, but for GRN 05 it was important. Although the reflection states that there are *Care* strategies that can be learned, others are inherent in the personality of the *Care* RN. In the last reflection, GRN 05 states that the most important strategy that has been learned is to 'be there'. This was a important lesson in the power of presence.

The *Care* enactments/strategies/skills imbedded in incidents ranged from a few lines to a single incident that took almost a page to relate. GRN 48 tells in a few lines about the RN who *just by phoning a client …to see how they are* showed *Care*. The RN knew that the patient had gone for a doctor's appointment. It was for the new GRN (and the client as well) the manifestation of a *Care* moment. Other skills needed no incident and were simply tied to the *Care* RN … *he shows he cares by his willingness to listen. GRN 12*

The analysis process

It is important to note that the aim of the research is intensely practical – an attempt to find out how *Care* is enacted. I was aware of the limitations of trying to quantify *Care*. One of the reasons that the words "enactment/strategies/skills" were used was to indicate that essentially *Care* is a synergy of skills. Skills that generate a *Care* moment for a patient are difficult to reduce to paper or as Farmer (1992) remarks "defies quantification" (p. 537). It could be argued that this type of analysis was a travesty of the time and effort that was put into the reflections by the participant researchers. There was a sense of the cliché in the listing and counting of the common *Care* skills such as listens (25x), touch (20x) and intuition (16x). "Caring is not therefore a series of predetermined isolated actions but manifests as patterns of interaction not regulated by rules" (Farmer, 1992, p. 537). It was these "patterns" that were being sought in the interpretations.

The initial analysis process involved reading the reflections a number of times on different occasions in order to get a feel for the data. I became immersed in the reflections and began to know them and although I could not identify any of the writers I imagined some of my ex-students participating in the patient care.

The reflections were then read and marked with different colored highlighter pens and colored pencils. Lists were compiled on a number of occasions with a new copy of the reflections. These lists were all hand written and contained a variety of specific enactment/strategies/skills and included characteristics such as 'kind' and 'happy'. For the GRN these were important components of *Care* that had been asked for. Most enactments could be named but some were less well defined. Registered nurses were described as 'coming from the inside' or *Care* enactments as being 'tuned in' or 'thorough'. Words from the reflections were used to define these less

easy to name categories, such as ‘they do not forget’ went into the ‘not forget’ enactment category.

REFLECTION

> There were new lists and old lists and lots of paper floating and blowing around. They were the early days and my word-processing skills were very basic and all the lists were hand-coded and written. I am grateful that the analysis was done prior to my being able to produce files and folders and delete at will. I reflect that had I been able to do this, the immersion in the data would not have been so complete and the lists would not have been accurate. In those early days of using a word processor I can imagine my deleting/adding/deleting categories and not remembering what I had deleted. I have not kept those very early lists but some were very long as each identified action was recorded.

Some of the GRN thought a particular enactment important enough to mention it in more than one reflection or gave more than one incident to illustrate an enactment. In this case the enactment is counted either twice or three times. However if an enactment is mentioned twice in a single reflection or incident it was only counted once. The GRN used the reflections to comment on their experiences and what they felt about *Care* as they perceived it to be. As a result the voice of the GRN became part of the analysis and later the interpretation. They were in essence the co-researchers of this research.

The enactments were combined, separated and then combined again. I became immersed in the data. Some of the specific enactments remained unchanged, such as ‘listens’ but other themes that emerged, such as ‘reading’ the patient, were incorporated into ‘intuition’. This was not done at one sitting or even over one weekend. The process was one of continual emersion in the reflections until I felt as if I was a participant with the GRN. This was the initial list of enactments. These were a mix of enactments and *Care* (and non-*Care*) behaviours.

I was finally convinced that the use of a computer program to contain the data would be useful. Nvivo, a program for tracking qualitative data, was selected. The transcribed reflections were then transferred to Nvivo. This allowed easy access to

the documents. A number of analyses were done on Nvivo. The Nvivo analysis served as a springboard to further explore the data and tag important phrases, and transfer the phrases into a number of what are called Nodes in the Nvivo program. A list of 47 *Care* enactments was entered into the Nvivo program. From these initial 47 Nvivo nodes I merged similar ones (eg. 'Gentleness' and 'Kindness' in context fitted into '*Care* from within' and were subsumed into that node) to produce a list of 28 *Care* themes that dominated the reflections. Non-*Care* had to be included in this list as its frequency was so high.

The program became an important part of tracking key phrases containing enactments in the reflections. The reflections had indeed become part of my life. I easily remembered the words and the phrases, and could find them instantly when a particular reflection was in front of me. I could not always match the GRN number with the phrase that would spring to mind. This is where the Nvivo program became useful. When I needed to find who had written a particular word or phrase Nvivo always found the reflections at a click of the mouse.

TABLE 5.2 Frequency of *Care* Enactments

GRN n = Number of GRN

Reflection n = Number of times the topic was apparent in the reflections

***Care* ENACTMENTS**	**GRN n**	**Reflection n**
Non-*Care*	15	41
Care from within	15	31
Go the extra mile	14	23
Listens	13	25
Puts patients at ease	13	20
Touch	12	20
I want to be *Care*	12	17
Active interest	11	17
Care toward others + me	9	11
Can be learned	8	13
Respectful of family	8	12
Settling in	7	11
Professional	7	8
Intuition	6	16
Identified by patients	6	11
Team	4	6
Holistic	4	5
Taking time	3	4
Unconditionally	2	4
Persistent	2	3
Empowering	2	2
Making a difference	1	2
Self care	1	2
Enjoy their job	1	1
Hard to define *Care*	1	1
Manners	1	1
Not judgmental	1	1
Simple things	1	1

The *Care* enactments are in rank order of the GRN n column which has the number of GRN who addressed the topic.

The second column indicates the number of times that the enactments/strategies/skills were discussed in the reflections. Only five enactments were only mentioned once.

Clustering the *Care* enactments

A secondary analysis took the most frequently mentioned *Care* themes – those mentioned by at least 25% of the respondents – and combined them into like categories. These categories were called 'clusters' and three were identified. The voice of the co-researchers was evident and had to be included as a separate cluster. The second cluster was included because the GRN found it difficult to separate the *Care* RN from the enactments. The third cluster was the enactments themselves.

TABLE 5.3 *Care* Clusters

GRN n = Number of GRN

Reflection n = Number of times the topic was apparent in the reflections

***Care* CLUSTERS**	**GRN n**	**Reflection n**
First cluster: The GRN voice		
Non-*Care*	15	41
I want to be *Care*	12	17
Can be learned	8	13
Settling in	7	11
Identified by patients	6	11
Second cluster: Attributes of *Care* RN		
Care from within	15	31
Care toward others (and me)	9	11
Professional	7	8
Intuition	6	16
Listens (the ability to hear)	*13*	*25*
Third cluster: *Care* Enactments of RN		
Go the extra mile	14	23
Listens	13	25
Puts patients at ease	13	20
Touch	12	20
Active interest	11	17
Respectful of family	8	12

(Listening was often linked to the caring attributes of the RN and so 'listening' is included in both second and third clusters. It has been printed in lighter ink in the second cluster, as Listening is discussed with the third cluster.)

The first cluster, the GRN voice, was significant and different enough to be classified separately. Without specifically addressing the way that they were coping with their new role and new environment, there were comments and snippets of

information which when pulled together gave a composite picture of the group. The GRN were starting their chosen career and part of the excitement and apprehension of this came through in their reflections. This was not surprising as lecturers had emphasized the value of reflection in the preparation for the GRN entry into practice.

The second cluster dealt with the RN. The GRN had difficulty separating the *Care* RN from the enactments that they were describing. This is not surprising as the two are difficult to separate. When the reflections were taken as a whole the differentiation became clearer and although an artificial division, it was easier to separate the RN and the enactments into two different clusters.

The third cluster dealt with the *Care* enactments themselves. The labeling of these enactments took the words from the reflections, some were straightforward, for example, 'touch', and unsurprisingly were the *Care* enactments from the literature. Others such as 'putting patients at their ease' and 'active interest' were the words that the GRN used in the reflections.

The first cluster – The GRN voice

The voice of the GRN, the co-researchers, are dealt with first. The GRN group gave an interesting insight into how they were feeling and the way in which they perceived their new world. The enactment/strategies/skills had reflected the 'ordinariness' of nursing but they also reflected special moments for the writers. The participant co-researchers reflecting had given a glimpse into the first weeks of their new career. These were *their* reflections. The incidents and the feelings that crept into the reflections were at times powerful – the voice of the GRN and the power of the incidents are dealt with first in order to situate the interpretation of the data.

Table 5.4 The First Cluster: The GRN Voice

GRN n = Number of GRN

Reflection n = Number of times the topic was apparent in the reflections

First cluster: The GRN voice	GRN n	Reflection n
Non-*Care*	15	41
I want to be *Care*	12	17
Can be learned	8	13
Settling in	7	11
Identified by patients	6	11

There were two overwhelming impressions that have never dulled. The first is that many of the group voiced their dream of being a *Care* RN (and a sense of their disappointment at the non-*Care* RN and their apparent need to give voice to the concept). The second impression was that, in spite of everything, they were coping with their new environment.

Within these perceptions of their new world there were thoughts and even judgments related to *Care* that emerged from their reflections. The word judgment has been used deliberately as the reflections carried a sense of judgment on the non-*Care* RN that the GRN had encountered. It was an overriding concept, an issue that will need to be dealt with. Closely related but different is the theme that *Care* was clearly identified by patients, giving some of the GRN a sense of fulfillment and affirmation. Finally, there was an interesting observation that the GRN felt that *Care* could be learned.

An anticipated problem was that there would be some evidence from the GRN of difficulties of settling into a new environment. This would probably be a limitation in the research. I could live with that. I wanted a fresh approach. If I had left it too late, the socialisation process may have distorted the fresh GRN vision. Recently there has been some discussion on the lack of mentorship and problems within the workplace environment as factors contributing to the nursing shortage. Cowin and Jacobsson's (2003) conclusion is that the education sector has been made a scapegoat for the high level of attrition once the graduates enter the workplace and that the profession itself needs to deal with the issue. The reflections echo these

problems. The 'lack of mentorship' is explicit at times and implicit in the references to the un-*Care* RN, and the workplace is also identified as being problematical.

Non-*Care*

The Non-*Care* RN was an unexpected outcome and in purely numerical terms it was the most common theme in the reflections and therefore the first enactment in Tables 5.2 and 5.4. Unexpected too, was the force with which the Non-*Care* RN were portrayed. It was a confirmation of the anecdotal non-*Care* in hospitals, but was not part of this research.

It must be carefully noted that although the RN have been categorised as non-*Care*, it is only in nursing that they have been perceived as non-Caring in the specific clinical milieu of that particular reflection. The abbreviation *Care* is specifically 'Caring in nursing'. In other words neither the GRN nor I are intimating that they are non-Caring in their personal lives.

Fifteen GRN mentioned non-*Care* and commented on it on 41 separate occasions. It has significance in that it is included in the reflections and therefore warrants discussion. In order to gain some understanding of this aspect of the data and to deal with it efficiently, it will be discussed here.

It was while I was checking on some historical data that I came across the following. It was a brief discussion on the historical attitudes of patients to hospital admission; most poor patients were illiterate and could not leave any accounts of their hospitalisation. However for an actor

> Joseph Wilde, in the Devon and Exeter Hospital at the beginning of the early Nineteenth century, nurses were less caring than doctors: 'Her tongue kills more than the ablest doctors' cure' (Digby, 1997, p. 299).

It seemed that in this instance two centuries ago there were nurses who were non-*Care*. This analysis provides a picture of nursing in which some RN *Care* and others do not. It was a stark picture of the reality of nursing. Only months previously, a senior clinical RN who was about to start a research degree said to a colleague 'I have got to a stage where I have to stop *Care* as I can't change anything – everything is about money these days' (used with permission of both people). It is almost as if there is not a continuum of *Care* - only a dichotomy.

The variety of non-*Care* behaviours was extensive, such as the fact that the non-*Care* RN were those who did not do much work and were happy to 'stand behind the nurses desk' GRN 23. Individual characteristics such as being cranky, rough or resentful through to generalized comments such as not enjoying their work or that nursing is only a job *that doesn't pay enough GRN 14* were common.

Only three behaviours occurred more than once. Unlike the other tables, the following table only gives the number of GRN who actually cited these behaviours in their reflection.

Table 5.5 Analysis of Non- *Care*

GRN n = Number of GRN

Non-*Care*	**GRN n**
Not giving the necessary care	7
Not professional	5
Lack of respect to patient	3
TOTAL	15

Fifteen of the GRN cited non-*Care* in their reflections. This is 63% of those who responded. There were 41 indications of non-*Care* behavior by RN. (Four GRN indicated that the RN had not been *Care* toward them.) This research is into *Care*; therefore the non-*Care* references have not been analyzed in detail. It could be hypothesized that the GRN were entering their chosen career with high ideals and as reality bore down on them were saddened or disillusioned and used the reflections to vent their frustration.

Some comments, which exemplified the non-*Care* RN, are -

They just don't give a shit. GRN 23

Those RN's who aren't as caring are observed to be quick tempered with patients and less willing to full fill their requirements. GRN 08

Where are the caring RN's? GRN 25

There was no need to interpret the non-*Care* theme. While a lack of respect and not being professional are not acceptable, the figure for patients not receiving the necessary care is disturbing. Seven GRN specifically wrote about care that was not

given to patients, 29%. The issue of non-*Care* is too high for complacency and a serious issue that should be followed up.

Three reflections indicated that the respondents had entered the graduate year with a clear idea that they did not want to be non-*Care*… an impression that had been formed by observations during clinical experiences while they had been nursing students. These impressions of non-*Care* that were witnessed were obviously clear and strong enough to make lasting impressions on the students. Two GRN did not give any details of the incidents. The third GRN related the non-*Care* incident in some detail. The incidents had served as a negative reinforcement of their ideal of the *Care* career that they had entered, and an example of the power of role modeling.

Although Watson (1999) does not discuss non-caring, there is mention of it in her discussion on a hologram metaphor for the Era III/Paradigm III. The transpersonal caring/healing paradigm/framework includes the concept that a "consciousness" is communicated to the patient. Significantly, in brackets, she notes that "non-caring non-healing" can also be communicated to the "one-being-cared-for" (patient). It is a philosophical discussion in which the concepts "go beyond the physical matter orientation of reality and healing" and states that a Caring consciousness is a form of energy that is not static but is evolving (p. 111). The metaphysical nature of Caring and the power of Caring-healing consciousness are explored. Such Caring is transcendental and cannot dictate specific skills being explored here.

A description of the consciousness of metaphysical *Care* is outside the parameters of this thesis. However, an understanding of this type of *Care* consciousness is increased when the GRN reflects on the *Care* RN who *ooze care GRN 12*, or that *It stands out GRN 24* or even that the RN is *just nice GRN 35.* These comments give a more concrete meaning to the concept. These descriptions are, however, not as clear as the reflection from GRN 35 about a non-*Care* nurse and a patient with dementia. The concept of transmitting the consciousness of *Care* (through an example of non-*Care*) assumes a reality not seen before. It is the patient with dementia who is able to 'discern' the non-*Care* nurse. It is the epitome of the metaphysical *Care* consciousness described by Watson and discussed above.

I like some of the nurses here, but some aren't very nice. (GRN 35 quoting the patient.) *When she can't even remember she just ate her dinner, or*

what happened 5 minutes ago. (GRN situating the patient's condition in context) *GRN 35*

REFLECTION

> I reflected on the non-*Care* nurse. Anecdotally and experientially the notorious 'Ward Sister' of yesteryear was *only* terrifying to the student nurses – unlike the sister described by Joseph Wilde over a century ago. The patients, for the most part, found her not only displaying a tough tender loving care but also, always, an expert in general and specific (to their disease) physical care. One of the unforgettable, the Ward Sister of the Private Wing, used to throw a dinner plate at a student nurse if she was so 'brainless' as to dare give a wrong diet to a private patient. (Only possible, because the patients could not see this behaviour.) The patient care was excellent – for all *her* patients … and it was Sister Brown who always got the chocolates.

This analysis on the non-*Care* RN is brief and no further discussion or analysis will be undertaken. It is not the focus of this research and a debate on this area is unnecessary. The presence of the non-*Care* RN is obvious. It is a phenomenon that for this research is no longer anecdotal.

I want to be *Care*

There was also an excitement that could be caught in the reflections. Going into the real world, many felt that they had made the right decision. They confidently wrote about the *Care* as if they knew all about *Care* and so were in a position to make judgments about *Care* enactments/strategies/skills. Although 50% of the respondents specifically reflected on their choice of nursing as a career and a desire to be *Care*, such as GRN 05, the theme of personal *Care* was far higher – and in a broad sense could be read into every reflection.

All I have ever wanted to be was a nurse and care for patients but now reflecting back what I truly meant was to care for and be caring to patients, show them empathy and give them the support they need. GRN 05

One of the first nodes that were made in the Nvivo analysis was 'iwantobe'. The meaning had to be clear and one that the researcher would not forget or 'muddle'

with another label. 'iwantobe' is in essence 'I want to be a *Care* nurse and in fact I have always wanted to be a *Care* nurse and I think I am already in some instances'. The personal nature of reflecting allows for such thoughts. These reflections, however, were focused by the research question and so it is surprising that there was a certain amount of self-disclosure. Some of the respondents made specific statements about their thoughts and aspirations in nursing such as the reflection from GRN 05 above and the thoughts of GRN 24,

What I know comes naturally as I want to be a caring nurse, nursing is something I have always wanted to do, be and excell at. It is part of a passion for me. GRN 24

Other respondents were not as clear but the essence of the reflection culminated in a phrase such as *I will learn from it and hopefully become a more caring primary nurse. GRN 23* This GRN made it clear that they had the notion of 'I want to be' in mind when the reflection was written. Some of the respondents repeated their desire to *Care* as if to emphasize that they were really clear in their desire to be *Care*.

I expected the participants to look at themselves, perhaps wrestling with shift work and lack of support, and wonder if they had made the right career choice. Was the three years at a university worthwhile? Is this what they really wanted to do? This reverse of 'iwantobe' (qualms about their decision) for two respondents was strong enough to mention it in the reflections. In an interesting twist GRN 25 comments in the first reflection, *What kind of a career choice have I made? Is this what I want to become? GRN 25* It is almost a cry of desperation. The reflection does not give any clue as to what might have occurred to elicit such a comment. But by the third week GRN 25 was able to comment, *During this week I have heard many times from one particular nurse 'How are you going?' 'Can I help you?' GRN 25* The support from a single RN enabled this GRN to carry on and reverse the qualms about the decision to nurse that had been reflected on in the first week.

GRN 41's reflections are in much the same vein, the first one written possibly at the end of a bad day and the second reflecting a good day.

I used to think that nursing is what I wanted to do. The last week or so has certainly made me re-evaluate that decision. Staff shortages due to annual leave and sick leave have increased the load on the rest of the staff during this period. Even throughout this tough time staff are still committed to

maintaining adequate care. It is hardly surprising that nurses burn out. GRN 41

However, the second reflection from GRN 41 is revealing as the reflection on her own practice has at this early stage been affirmed**.** A senior staff member***…passed on a specific thanks to me from the patient and congratulated me on helping this patient to become more conversant than on previous admissions. GRN 41.*** This GRN then goes on to reflect that,

This experience has reassured me that even if it takes me a few minutes longer, it helps the patients to achieve the maximum level of health possible at that time. To me, that is what nursing is all about. GRN 41

Another GRN relates how she was given a box of chocolates and that the patient's wife,

……. was so greatful for the kind, caring treatment …I could not believe it…"I" had made a difference. Scary stuff.. The "simple" things I had picked up from watching others …actually worked. I want to keep acting the same way, as it helps to make others feel good which eventually makes me feel great. GRN 49

In addition to the experience itself, GRN 49 reflected and recorded it - no doubt it will remain etched in her memory as something special that happened early in her/his nursing career.

REFLECTION

I speculated on how long the 'tough time' of GRN 25 had been. Had some of the respondents, although they knew they were anonymous, wanted subconsciously to let me know that they were coping well? If this was indeed the case the questioning of the career choice would have been made as a 'cry from the heart'. The comment from GRN 41 and the system that had precipitated such a remark saddened me. Kramer in the USA first wrote about reality shock over twenty years ago, (M. Kramer, 1974) and it appears that the Australian scenario is not much different and the transition is not always easy (Heath, 2002; Reid, 1994).

Can be learned

A list of questions was included in the two letters that were sent to the GRN participants to guide them in their reflections. It was something to generate their thinking on *Care* as they started working and then writing their reflections. There were thirteen questions in all, some that were tangential to the issue such as 'Is this caring an art?' and 'Do you think this kind of caring can be taught?', while most asked the first question of the research in different ways such as, 'How is this caring portrayed?' The question about the teaching/learning of caring that was the **only** peripheral question that eight GRN specifically tried to comment on or answer. While one third specifically commented on whether *Care* could be learned or not, in the reflections was the notion that the GRN themselves were learning *Care* from the RN. Almost every reflection used words like, I believe, I think, I know, to reflect how the *Care* incidents have in some way made an impact on themselves.

The comments/answers came from two perspectives. The first was that the reflections noted that Caring/*Care* was an innate characteristic and the other was that it can be learned – a totally predictable split of responses. The innate characteristic of Caring is dealt with in the context of the Caring Attributes of the RN and is summed up by the comment that,

……Some people are just born to care, nursing allows them to do this. GRN 12

It is an interesting philosophical comment and something worthy of dialogue. The question can be posed as to whether nursing allows a Caring RN to show their Caring nature or if the RN is simply using *Care* tactics learned over a period of time. The dialogue can then be extended as to whether the *Care* RN will Care outside the nursing environment.

The GRN who felt that *Care* could be learned were positive in their reflections about this fact. The references to the role model of the RN such as GRN 32 were very direct.

The nurses that I have the greatest respect for & one's that I wish to imitate are one's that deal with patients in a kind & understanding manner & the difficulties that they have with patients ends with them. GRN 32

GRN 25 values the learning afforded by the experienced RN and wonders what will happen to the profession when the older RN (and Enrolled Nurses) retire.

There is great teamwork here, although I also notice that there are two types of nurses here - new graduates and nurses (both RN's and EN's) who have been nursing for many years (15 - 20 Years), so what has happened to those who have only nursed for 5 - 10 years? I know I may be getting off tract here but are uni trained nurses more likely to leave general nursing and move on, branch out. If so what is going to happen when the older nurses retire? Who will remain in general nursing? Who will be there to Teach new RN's the art of Caring? A frightening thought. GRN 25

A second philosophical reflection on learning *Care* came from GRN 23. The GRN tells of a patient to whom *Care* is difficult to show, and then concludes with the notion that sometimes there is nothing that can be done to show *Care*. It is noteworthy that this GRN and the other RN seem to want to show *Care* and cannot. The whole incident is given in order to give an understanding of the final comment.

Admittedly some pts will bring out an intolerance and I know I do not give them enough. Either time or consideration. But I believe that is with every nurse. There is one pt that I know I do this to. Along with other problems she is behavioural. She will urinate where she sits, defecates where she sits, lie in it, not shower and just really poor personal care. I cannot say I do not care because this is not true. I do care. I care about her poor self image and other deficits that have left her this way. But I am having trouble getting through. I don't know whether to my self or her but I just don't feel I can help her. With other patients talking, listening can help but not with her and if it does you cannot recognise it. But with her I am not the only one having 'caring' issues. Other staff, more senior than myself, throw their hands in the air and don't know what to do. I think if you could learn everything there was about caring and still not be able to handle every situation. GRN 23

Within the uniqueness of humanity and the multitude of responses to sometimes ordinary events, one simply cannot learn all there is to learn about *Care*. It is possible to speculate that with the above incident/reflection, at some time a *Care* nurse will connect with this particular patient. *Care* is a concept that will enable the Cared-for to know *Care* but the same strategy will not necessarily work next time with a different patient. In other words the essential factor in *Care* is the nexus of

complexity and experiential uniquenesses. Just where the nexus is cannot be determined and therefore cannot be taught.

Imbedded in the concept of learning *Care* by watching a role model is the notion of *Care* being learned over a period of time. It is learned through experience. Perhaps it is by watching the *Care* and the Cared-for.

I believe that different experiences can allow people to become more caring as time goes on. GRN 15

The act of caring may be perfected over time just as an artists or actors skills may be perfected. So too it is possible to learn new forms of caring. GRN 35

This concept of learning *Care* through experience is brought out in the literature. (Kosowski, 1995; Patton & Woods, 1995; L. Wilkes & Wallis, 1993; L. M. Wilkes & Wallis, 1998)

The construct of teaching and learning *Care* is dealt with in more detail in Chapter 6.

Settling in

After spending three years at university and having had numerous warnings about being sure to practice safely, it is probably not surprising that the GRN would be apprehensive about their beginning practice. The initial stages of analysis indicated that some were finding it difficult to settle into their new environment. This was not entirely surprising as the clinical hours in the undergraduate programs had been steadily reduced and the current climate of health care, discussed in Chapter 2, is difficult. This in fact was reflected by some of the participants. There were eleven passages that seemed to indicate difficulties but in context all but one rose to the challenge of the new workplace. A typical example is GRN 41

Life as a new graduate definitely poses some new challenges, some exciting, others quite frightening. Some of these new challenges I have discovered include not thinking like a student but rather as a registered nurse. Grn 41

GRN 32 mentioned the current problem of a lack of RN in the health care system. This understaffing possibly results in non-supportive care for the new graduates.

After 4 weeks of working it is my experience to find that most nurses even though some are caring for PTS show little care for each other. This is because they are tired and focusing on their own workload only. They have little time to help others in their ward. GRN 32

The "little care for each other" that is described by GRN 32 is seen again. GRN 30 was more descriptive about the same problem and gives some detail.

The first day of the graduate program, my first official day as a Registered Nurse was very exciting and frightening. That particular day, the ward was understaffed of nurses much more than usual. I watched nurses hurrying around trying to complete their tasks rushing people in and out of showers, giving out pills taking part in nothing that would take up time, for example talking to patients. It seemed completely opposite to what I had imagined nursing to be. After speaking to one of the nurses on the ward I was told that talking to someone is not going to save their life, doing obs, giving out meds etc. is vital. I was told that it is all about priorities when a nurse has limited time. GRN 30

GRN 25 was more specific and, interestingly and perhaps significantly, was the only one to make a comment about the Bachelor of Nursing program when the remark about the length of the 'practical' was made in the second reflection.

I have had a difficult time adjusting. I look around me and feel overwhelmed and under-prepared. Yet I find that I am so tied up in trying to cope with all the new things that I see, there are so many new experiences that I didn't see or do as a student (yet another reason for there to be heaps more practical in our courses). GRN 25

GRN 25 is more positive in the third reflection about a *Care* RN that has obviously taken GRN 25 under 'her' wing and is very supportive.

A closer analysis of the reflections found that there were only two GRN who were specific about problems of settling in to the new role, GRN 30 and GRN 50. GRN 30 who found the first day 'very exciting and frightening' as a result of understaffing (reflection above), concludes the reflection with,

It seems that situation was a 'once-off'. For the rest of the week I was given low patient loads so I could acclimatize to the 'real world'. GRN 30

This indicated in some way that 'she' had settled in. The fact that it is the only reflection that was sent in from GRN 30 is of some concern and is perhaps a

problem of reality shock. Conversely, the reflection ended on a positive note, and the fact that no further reflections came in could simply be part of the adjustment to a new life style, working full time and coping with a new career. GRN 50 also appeared to be having problems. The entire reflection (the only one) is given.

I have worked 3 weeks. In my first week as an RN I found that the way I enacted caring felt very basic- I felt I wasn't giving all the care I wanted to. In my first week I was trying to give medications on time, take ob's & BSL's at the right time, I was trying to orientate myself to my surroundings as I didn't have any form of introduction to the ward. I was trying to look like I knew what I was doing. I found it very difficult to give the care that I wanted to in my first week. I was so stressed about the technical side of my job. I've always seen a good caring nurse as being someone that actively cares for the whole person & is aware of all their needs. At this stage I was trying to keep on top of caring for my pt's physical needs. GRN 50

Except for GRN 30 who appeared to be settling down and the concern of GRN 50, the group as a whole was perceived to be self assured and happy in their new environment.

There is ample anecdotal evidence that indicates that graduates take as long as six months to settle into the role of RN. Although there was some ambivalence, the GRN as a group reflected with confidence and gave the impression that they were settling in early and well. The workplace environment gave concern to some. GRN 05 is very explicit in the problems that are faced by families and the health care system.

Caring as I have also discovered is restricted by hospital policy. Once such incident in which a … and details are then given of a family situation. This created much stress and tears of the family and placed nursing staff in an awkward position. GRN 05

The costs of litigation and a contiguous drive for safety mean that there is a sense that the hospitals are driven by rules and regulations. The patient and family are sometimes left out in the cold, leaving the nurses in a difficult position as they attempt to be *Care*.

GRN 35 infers that there is a problem of high workloads in the hospital that has made it difficult to identify the *Care* enactment/strategies/skills of the RN.

I have found it difficult to identify more caring actions or episodes as I don't spend any time with other nurses as I have my own patient load ….. GRN 35

In another situation the focus is on the hospital layout and the impact this has on the ability of the GRN to observe or enact *Care*. The wards are usually single bed private wards and often have their own ensuite. The action is not visible, taking place in private, behind closed doors.

Being in a private hospital setting I find I don't often get the opportunity to see the caring that others provide. GRN 25

In spite of this and in the context of all the reflections written by GRN 25, there was sufficient opportunity to identify the *Care* enactment/strategies/skills of the RN.

Identified by patients

The relationship between the patient and the GRN was different to the relationship that is often described by students in debriefing sessions after clinical experience. The supernumerary standing possibly gives the student time to chat to the patients giving a sense of informality to the relationship.

Patient care was now being taken seriously by the GRN and there was a sense of an attitude of responsibility and accountability. Full responsibility for the nursing care of patients put a different perspective on patients. This new perspective needed to be kept in mind when the interpretations were being made. The GRN were possibly taking on their professional role, at a subliminal level.

The sense of responsibility of the GRN to the patient that was indicated in the reflections is not always reflected in the literature, particularly in the textbooks. Some of the literature uses the words 'client' or 'customer' instead of 'patient'. This is suggestive of a contractual agreement which then falls outside the connotative meaning of the word 'patient' and the implications of *Care*. Parker likens this change to a supermarket where health is a commodity and the patient simply a consumer. In nursing care the relationship should be one of *Care* and the accountability one of responsibility, and not financial. (Parker, 1999) By inference, the supermarket care that would then be given would be in the same category as the medical domain, simply safe and competent.

It could well be as Fletcher suggests that patients perceive that the 'cares' that they receive in hospital are indeed *Care*. (Fletcher, 1997) GRN 06 in his/her first reflection seems to have tumbled to the same conclusion. After describing a post-operative patient receiving good pain relief, GRN 06 describes helping another post-operative patient with a shower who was

…… hesitant to undertake a shower because of discomfort and unsteadiness of her feet. I assured her that I would stay with her, help her with whatever she needed and that I would not leave her. The following day when I had to shower another post-op patient in the same room who was also very unsteady on her feet, had been vomiting or nauseous, the first patient praised my previous efforts to this patient and told her not to worry stating that 'She's the best nurse, she helped me. She'll help you.' GRN 06

GRN 06 obviously feels that this is important and again later on remarks that,

Although these acts of enacted caring are what I deem fundamentals in the delivery of nursing care, patients really do perceive them as acts of caring, especially when they are not done on 'automatic pilot' and are individualized. GRN 06

For GRN 06 there was clearly surprise in the fact that the patient wanted what she/he considered just the fundamentals. Perhaps what is sometimes forgotten is the ordinariness of nursing (Taylor, 1994) and the extraordinariness of the situation the patient is in. Being human in a strange and often frightening circumstance, the patient is grateful for help and consideration in such mundane activities as showering or bathing.

Patients do want consideration and when they get it they will show appreciation as is indicated by GRN 49 who in the context of the incident is surprised that this has occurred.

As soon as this was asked, the family looked relieved & comforted that somebody cared about their distress. They were extremely grateful. They gave the staff a heartful thank-you card & a huge box of chocolates. GRN 49

And then GRN 49 in the next reflection tells of another box of chocolates…

His wife came with a box of chocolates for me - she was so greatful for the kind, caring treatment that I offered both her & her husband. The patient agreed. Apparently he had asked his wife to get them. GRN 49

And then, possibly a rare occurrence, but noted twice in the reflections, a patient speaks up and tells the GRN 32 about her negative feelings.

A patient being discharged had made the comment that she hoped that the staff don't talk about her the way that she heard the nurses talk about the lady that was in the bed next to her, this lady was very upset and distressed of how the nurses spoke about her fellow patient. GRN 32

In spite of the need for the GRN to give safe, competent care, it is interesting to speculate that the relationships between the GRN and the patients were perhaps in a stage of transition. Although in the above situation the sense of responsibility and the newness of the situation were possibly present, the GRN had established enough trust with the patients for this patient to voice her concerns.

In the second incident a negative reaction from a patient is recorded. It is an incident that has been quoted already, but repeated here as the focus is different.

We also have patients waiting nursing home placements. These patients can definitely see which nurses they like, and perceive to be caring. Even a patient with Dementia can discern that ….. "I like some of the nurses here, but some aren't very nice". When she can't even remember she just ate her dinner, or what happened 5 minutes ago. GRN 35

This elderly patient who identified nurses who weren't 'very nice' was not the only patient for whom non-*Care* RN were a problem. Other patients identified non-*Care* as GRN 32 notes above.

The *identification* of the *Care* nurse is not important for this research. It was the actions that were being sought. Although there is a plethora of research on *Care*, Caring attributes and Caring actions, the fact that the patients always identify the *Care* RN, informally and formally, is important and I argue does not need research. It should be a given - good care by competent RN. The personality of the RN did not appear to matter. In fact, in the above instance, the patient had Dementia and identified a non-*Care* RN. In other words, it is almost immaterial to the patient about the personality; it is the way in which the patient is act-ed toward or sadly …not.

The current literature on the patients' perceptions of the *Care* nurse mirror some of these reflections. In a qualitative Australian study patients were interviewed concerning their perceptions about *Care* and nursing care. There was an emphasis on the quality of physical care as well as delays in answering the call-bell and a lack

of presence (Irurita, 1999). A second Australian study by Gardner, Goodsel, Duggan, Murtha, Peck, and Williams (2001) replicated Larson's Scandinavian quantitative research on the *Care* characteristics/behaviours of nurses. In the discussion, Gardner et al indicated that the results were similar to Larson's research. In summary the patients valued physical care higher than the affective behaviours valued by nurses (Gardner et al., 2001). Gardner et al and Irurita both briefly discussed the fact that some RN are not *Care*. A British qualitative/quantitative study found a distinct lack of person-centredness in health care, with patients reporting that they were treated like numbers or a piece of meat (Coyle & Williams, 2000).

A small study in the USA found positive and negative reactions in response to the level of patient satisfaction (Schmidt, 2003). These studies, together with the fact that the GRN found non-*Care* RN, is of concern, and leaves room for further study and remedial action on the part of the profession. Kelly's brief review of the literature on patient satisfaction, and the importance of seeing the patients holistically, was reflected in a paragraph entitled *The patient is king* (Kelly, 2004). Perhaps this is the point that the patients in the above studies were trying to make. The adage 'that the customer is always right' is a concept that should be more pervasive in nursing care. It has taken a long time for nurses to learn the proper definition of pain – what the patient says it is. Hopefully it will not take as long for nurses to learn that the 'the customer (patient) is always right'. Needs and wants enter the equation here and thus it is an area that is problematic and one in which discernment on the part of the nurse is a key factor.

The *expectations* of patients, as opposed to patient satisfaction after the event, have not been considered and research in this area may well benefit the nursing profession. Investigation of patient satisfaction after the event means that the patient is in a recovery period, or worse, is still ill, and conceivably worried about the effects the injury/illness is going to have on their lives. There seems to be an indication that the patients also expect Caring clinical care – even the shower post operatively was considered part of the '*Care* care' and there is no research on this aspect of basic care that could be located. Patient satisfaction is becoming increasingly important, even more so than when Fosbinder's (1997) research on interpersonal competence of nurses was published ten years ago. Fosbinder (1997) concludes her research with the comment that further research into patient satisfaction is 'imperative' and that,

"With the recent impact of consumerism and competition, patient satisfaction is now key to hospital survival" (p. 1091).

The voice of the GRN sets the parameters for the second and third cluster. The new found confidence and a *Care* focus that the GRN wanted for themselves as well as knowing that patients know the *Care* nurses, gave the GRN a focus and the right to write about *Care*. It was as if for the individual GRN there needed to be parameters prior to describing the *Care* enactments.

The divide between the *Care* RN and the *Care* enactments in the individual reflections was not clear, in spite of the research question and the intent of the question being very specific. What are the *Care* enactments? How is *Care* shown? Collectively there was a clearer demarcation. The second cluster of themes extracted from the reflections was the *Care* RN. It is to these *Care* RN that the discussion will now turn.

The second cluster – attributes of the *Care* RN

The *Care* RN (their personality was never mentioned or inferred) and their enactments/strategies/skills was often treated as one in a single sentence. The *Care* RN was an integral part of the way the *Care* skills were enacted. What stands out in the reflections is that the *Care* skills and the *Care* RN were difficult to separate, and as the question asked about *Care* enactments, this is surprising.

Overall, a profile appeared of the *Care* RN that was a combination of formal and informal attributes and skills. On a formal level, the RN was professional and knowledgeable and was able to work in a team. On an informal level, the RN was genuine, gentle, kind and understanding; an ordinary description of extra-ordinary people. The attributes of the *Care* RN will be dealt with briefly, as the concept was an integral part of the reflections.

Table 5.6 Second Cluster: Attributes Of *Care* RN

GRN n = Number of GRN

Reflection n = Number of times the topic was apparent in the reflections

Second cluster: Attributes of Care RN	***GRN n***	***Reflection n***
Care from within	15	31
Care toward others and me	9	11
Professional	7	8
Intuition	6	16
Listens (the ability to hear)	*13*	*25*

(Listening was often linked to the caring attributes of the RN and so 'listening' is included in both second and third clusters. It has been printed in lighter ink, as Listening is discussed under the third cluster.)

There are only four attributes that were counted in the analysis. The first two, 'Caring from within' and 'Caring towards others and me' were two attributes that included a wide range of descriptors. The descriptors fell easily into the attributes as the incidents clarified exactly what the RN was 'doing'. On their own the attributes could have lacked clarity. The third attribute was easily counted – the word 'professional' was used. However, the professionalism of the *Care* RN was never described; there was an assumption that the writer and the reader knew exactly what being professional entailed. (The non-*Care* RN who was considered to be acting in an unprofessional way was sometimes defined, such as a lack of confidentiality in hand-over). The last attribute, 'intuition', was easily identified and counted as either the word 'intuition' was actually used or it was clearly inferred. Intuition was described by six of the GRN who referred to it on 16 separate occasions.

Care from within

That caring came 'from within' was for a number of the co-researchers simply that. There was no explanation…however it was 'expressed' by the RN it was clearly evident to others and the GRN.

…..Some people are just born to care, nursing allows them to do this. GRN 12

…..but it also is a natural quality within people. Some people have this quality more pronounced than others, … GRN 18

…..their body language, their expressions identifies an essence of caring. You can see at as another nurse, you can identify it as a patient. It stands out. GRN 24

In spite of the above, there was a single instance of a RN who was initially identified as being non-*Care*. Subsequently the GRN worked with this RN and found, probably surprisingly, as that is why it was recorded as a reflection, that the RN was indeed gentle and *Care*. The adjective that was initially used to describe the RN was 'brisque', hardly a characteristic that would convey a *Care* nature. The Oxford Thesaurus has a note about this word and the confusion that occurs between brusque, curt and abrupt. Interestingly, the explanation states that the brusque person is one who "is trying to get a conversation over and move quickly onto something else". There is here a direct link to the notion of a busy ward and a competent RN who is, when with a patient, *Care*.

REFLECTION

> I reflected on a stressful time in our lives. Gil, my husband, was in hospital for major surgery. He identified early in his stay a RN who he surprisingly found brusque. Some days later when complications occurred and necessitated more attention from this particular RN, she was the most competent and the most *Care*. Her priorities were clear: patients that needed attention got it, *Care*ingly.

Describing the *Care* RN did not appear difficult. Although it is hardly academic or even polite to depict someone who is *Care* as oozing care, the comments reflected the honesty and reflective nature of the reflections. They had a ring of truth as the personality of the GRN shone through some of the remarks. These were reflections and not intended to be academic and as they were confidential the co-researchers could be 'themselves'. The *Care* literature is replete with grammatically correct sentences, either describing *Care* in multi-syllable alliterated words or in a lengthy list of synonyms. There was no difficulty in the analysis of reflections about the *Care* RN as the GRN had done the analysis already and told how it was. The *Care* RN was just that, *Care*. It was something intrinsic, or as one GRN commented,

It is like they ooze care or something. GRN 12

Eleven GRN reflected on the *Care* RN as a person, but it was GRN 35 who was also at a loss for words and finishes by simply writing 'just nice'

Caring is a part of a personality, their essence, something about them is…comforting…or…just nice. GRN 35

REFLECTION

I reflected on my school days when my English teacher frowned formidably on the use of the word 'nice'. In the reflection from GRN 35, the hesitancy fits with the use of the word. I can see them now, the many students, now RN who are 'just nice', wonderful *Care* nurses who I would be perfectly happy to nurse my family *or me.*

GRN 32 looked at the work environment in order to describe the *Care* RN. This particular nursing establishment (obviously private but no indication as to what type of 'Christian' it is) possibly chooses nursing staff carefully, but for GRN 32 the *Care* is embodied in a high standard of professional *Care* that is given to patients. The reflection notes that the

nursing establishment has a Christian ethic the staff are more concerned with doing their work professionally, because I feel that the staff who choose to work in these places, have a strong conscience about performing their work well and this means that the standard of care is higher. GRN 32

GRN 34 tells of an incident where the RN and the GRN are involved with what is apparently a patient and family who have just been told of the patient's poor prognosis and she writes that

The response of this family and pt to the nurse was overwhelming. GRN 34

In context, it is the whole incident that, to the new graduate is overwhelming. The *Care* RN had in a simple but profound way 'made a difference' to the patient, family and the new GRN.

All the RN's on my ward are caring, however the way they might show it may differ depending on their personality. GRN 35

The comment from GRN 35 probably says it all. The *Care* RN are as different from each other as the inimitability of humankind. The internal characteristic known simply as Caring was recognisable as *Care* although it was displayed in different ways.

In '*Care* towards others and me' the enactments were varied and yet were always recognisable as *Care*. The list included words such as honestly interested, supportive, accepting, and those with which the GRN felt comfortable. All very ordinary actions. The impact of the *Care* RN on the GRN did not go unrecorded. After watching a *Care* incident and a *Care* RN, GRN 49 reflects that

It showed that doing the simple things make a difference, something that I will never forget. GRN 49

Later in the next reflection GRN 49 reflects on how this then did work for her/him…

The "simple" things I had picked up from watching others & just using my own instincts & treating somebody how I wanted to be treated, actually worked. I want to keep acting the same way, as it helps to make others feel good which eventually makes me feel great. GRN 49

This research shows the importance and reality of an innate *Care* nature. The range of characteristics of a *Care* nature are wide, but a single characteristic that is clear in this research is the fact that the *Care* RN is able to intuitively tune into the needs of patients. In being able to tune in, the *Care* RN instinctively gives the *Care* that is needed.

Professional

The fact that the GRN linked being professional to the *Care* RN is interesting. It was not until I had worked my way through Phase II that I fully appreciated the importance of 'being professional' to *Care*. I regretted not having discussed 'being professional' with the participants at the Dialogue Day. Therefore this discussion is important as it was these reflections, as well as my research into the borrowed literature, that led to the emphasis on 'being professional' in the final framework. It is an interesting set of reflections as the notion of professionalism was in some instances linked to the non-*Care* RN. It is also interesting as it illustrates the mental leap-frogging in the reflections and the literature that led to the important emphasis on professionalism.

… During handover some nurses are not as professional in their attitude as others when describing their patients and their nursing care, and also do not show respect for their patients. The nurses receiving the handover portray their disapproval by raising eyebrows or exchanging glances amongst themselves. GRN 06

This first reflection does not comment on exactly what is meant by being professional. I hoped to find some comment on what being professional meant. None of the reflections expanded on the notion of professionalism. The next three reflections simply note that it is present and the fourth reflection simply infers a professional aspect.

Gentle, kind, attentive, Funny at times, Good conversationalist to pt, good communicators, patient, professional, intuitive. GRN 24

…doing their work professionally, because I feel that the staff who choose to work in these places, have a strong conscience about performing their work well GRN 32

I have seen a very professional level of caring instilled into the patients needs. GRN 41

The context for the reflection by GRN 11 is that a doctor displays a professional attitude in communicating to the patient and the staff take their cue; the doctor is taken as a role model in professional behaviour, and that the nursing staff became ...more responsible for the care given. GRN 11 The responsibility was obviously a different type of responsibility to the responsibility that had been emphasised during the student years at university.

I reflected on the concept of professional and that the GRN had recognized it so early in their professional careers. The change from the relaxed atmosphere in a university to the sometimes-rigid hierarchies in the hospital system does not always prepare the student for working in a professional environment. I comment on this again in the discussion on being a professional and professional communication in Chapters 6 and 7.

Intuition

GRN 24 uses the concept of intuition nine times as the *Care* enactment/strategies/skills are described. GRN 24 notes that there are four *Care* RN in the ward as well as some that do not *Care* and notes that Some patients are hard

to read and yet the *Care* nurse is 'persistent' in trying to find out what the patient needs or why the patient is 'distressed' and calls it 'nurse intuition' GRN 24 . The GRN must have felt that it was a special kind of intuition that is eventually learned by the RN and then gives an interesting example of an ordinary incident.

In one case stroked a child's neck as the child felt comforted by this, settled and when her mother was brought in told us her daughter liked to be comforted by having her neck stroked. The nurse identified what would be comforting to the pt. The caring I see portrayed is like a nurse intuition knowing what and how to comfort someone forfilling the needs of the pt, GRN 24

Interestingly both GRN 29 and GRN 18 do not have a word for it, although it is probably intuition that is being described.

…..sometimes we can pick-up bit and pieces which allow us to place them together to see where things fit. GRN 29

…..they have their perceptive antennas out. I think they go into the room open-minded and willing to meet the patients needs and make them as comfortable as they can be. GRN 18

If the concepts of the two reflections are combined they make an interesting definition of intuition. The ability to be 'open-minded' and take the 'bits and pieces' and 'place them together' as well as placing them into context is a skill and part of critical thinking that is emphasized in all the nursing fundamental texts. Or, it could be as I have classified it, intuition. The context of the two reflections does not indicate whether it is intuition or simply being observant and using critical thinking. The ability to be 'open-minded' is in itself complex and could not be taught. It is not a matter of being without prejudice, which is too narrow an interpretation of what is meant. It is a combination of taking knowledge and being at the same time open to what may be found in order to individualize the care. Taking all the concepts together it encapsulates the art of nursing (Paniagua, 2004).

The following two quotes from the reflections indicate that the GRN recognized it as something that was important, maybe even a new perspective on *Care* and what nursing was all about. There was a simple and straightforward acceptance of a complex concept.

…..couple of caring RN's - they are the one's who look beyond the obvious, who get down to the level of the patient, who don't rush away… GRN 25

They tune into their pts. GRN 24

There were only two occasions in the reflections when the word 'discernment' was used. In the first instance GRN 32 used it as a descriptor of a *Care* RN who was able to discern when a patient or family simply wanted to be left alone. It is an interesting aspect of this reflection that the GRN was able to identify that the RN was discerning enough to intentionally give the patients/families the time to be alone as well as classifying inaction as *Care*.

…..the discernment to sometimes just give them space and leave them be. GRN 32

On the second occasion that the word was actually used, the discernment is attributed to a patient and not an RN. It is in the description of a patient with dementia who was able to *discern* a non-*Care* RN. (Referred to earlier)

The intuitive nurse and the work of Patricia Benner is well known and widely quoted (Benner, 1984; Benner & Wrubel, 1989). Benner's, *From Novice to Expert* (1984) is based on the Dreyfus and Dreyfus model of ascending levels of proficiency, and her interpretation of the expert nurse is that the expert "has an intuitive grasp of each situation and zeros in on the accurate region of the problem" (p.32) and that the intuition of an expert nurse only comes with a sense of time. I disagree with Benner when she says that the expert nurse 'melds' the roles of *Care* and practice. The expert nurse is not the only nurse who can *Care*. I do agree strongly however, with her interpretation that *Care* "cannot be controlled or coerced" and that it can only be "understood and facilitated" (Benner, 1984, p. 171).

McCrea, Atkinson, Bloom, Merkh, Najera, and Smith (2003) highlight the novice graduate *Care* in a selection of stories taken from their research after the implementation of a professional practice model designed to foster *Care* in the hospital. A new graduate tells a *Care* story of some complexity during which she was able to bring about important changes through her skilled assessment (involving intuition and knowledge). The authors' conclusion refers to Benner's model and makes the comment that in spite of the fact that the graduate was a novice she still had a 'vision of the quintessence' of nursing (McCrea et al., 2003). The reflections in

this research confirm on two occasions in quite complex situations the *Care* ability of the new graduate.

The reflections did not (indeed, were not asked to) identify the RN or their level of experience. It is inconceivable to postulate that once a student graduates they have achieved the level of expertise of a RN with years of experience. The Australian Nursing Council Competencies make it clear that the competencies are at a beginning level. However it is just as inconceivable to hypothesize that all RN will progress through the hierarchical levels of novice to expert in a similar fashion.

English (1993), in a critique of Benner's work, suggests that the word 'intuition' is used incorrectly, indicating that the use of the word is subjective and that it has limited applicability. He maintains that intuition should not be used until it has been 'unequivocally' researched. English does not suggest an alternative. Guzzetta (1995) argues that intuition, as a right side brain function, can be used in establishing a nursing diagnosis. It is portrayed as being soft and not given much value and yet is a fundamentally important part of nursing knowledge. Unfortunately Guzzetta (1995) also uses the words "gut feeling" in her discussion on intuition, (p.164) the sense of the word with which English has problems.

Dossey's (1995) adaptation of Tolfia's research into the expert nurse is interesting. The characteristics of the expert practice nurse are tabulated and in the ten characteristics the words intuitive/intuition are mentioned five times in three of them. The notion of intuition is inferred in a further three characteristics. (Dossey, 1995) This emphasis on intuition is remarkable, considering the negative connotations associated with the concept (English, 1993; Paley, 1996).

REFLECTION

> I reflected on the notion of intuition. The possibility of using a different word began to surface. I wondered if 'discernment' was something that should be investigated. Semantic arguing is not always profitable but 'discernment' is linked to knowledge and an ability to use the knowledge. The possibility of using 'discernment' kept on surfacing until later in Phase II. The problem was that the research was to identify a skill and not an attribute or a characteristic. Intuition is something that could never be taught. The use of the word 'discern' in order to individualize care was perhaps something that was more skill and knowledge based. The ability to discern in order to personalize care, and be

> seen as *Care*, began to formulate in my mind. Although assessment is a skill that is taught and emphasised, it has become almost technical and related for the most part to the physical.

Almost ten years on there is another challenge to the work of Benner and Wrubel. Horrock's (2002) academic discussion with Benner and Wrubel (2002) is interesting and challenging. There are few practicing RN who would be able to sustain such philosophical debate. It is not the intention to enter the debate here. The argument is academic, yet has important considerations for the practical arena. Horrocks questions their (Benner and Wrubel) writing and asks,

> They argue that nursing can never be reduced to a mere technique because the meaning and effects of what the nurse intends can change in different contexts when interacting with different people. I take them to mean that there is a part of nursing experience that defies quantification (Horrocks, 2002, p. 40).

This is exactly the point. There can be no quantification of *Care* (or intuition). *Care* is beyond quantification, despite the efforts of some of the researchers in *Care* to do just that. It is also important to note that the philosophical debate about intentional caring and Heideggerian interpretations is of no concern to the patient or to practicing nurses. The philosophical interpretations are just that, interpretations. It is the practical, what happens in the day-to-day activities between patients and nurses, that defies quantification. The quantitative research on *Care* attempts, not always successfully, to *measure Care*. The important concept is that *Care* does exist although it cannot be quantified. But there is a factor that is elucidated in the reflections – that there are common cores of *Care* enactment/strategies/skills that can be shown to exist. It is to these *Care* enactments that the discussion now turns.

The third cluster – *Care* Enactments of the RN

The third cluster contains the quintessence of what was asked in the research question. What are the *Care* enactments? It was these actions that were being

sought. The *Care* RN and the context of the GRN themselves needed to be situated prior to the discussion of these enactments. The enactments in the following table are a distillation of the *Care* enactments described by the GRN in their reflections. It is in this section that the *Care* literature is discussed.

Table 5.7 The Third cluster: *Care* Enactments of RN

GRN n = Number of GRN

Reflection n = Number of times the topic was apparent in the reflections

Third cluster: *Care* enactments of RN	**GRN n**	**Reflection n**
Go the extra mile	14	23
Listens	13	25
Puts patients at ease	13	20
Touch	12	20
Active interest in the patient	11	17
Respectful of family	8	12

There are only two clearly defined skills (real doing.) – listens and touch. Although these are singularly important actions in nursing, they are also important in daily living. Touch would seem to be the most specific nursing skill. Listening was also included in the attributes of the *Care* RN (Table 5.6).

The remaining three enactments – the ability to put patients at their ease, taking an active interest in the patient, and being respectful of the family were more multifaceted and generic than listening or touch. The enactment that was mentioned by the most GRN was the concept of going the extra mile, again an enactment that can be considered generic to Caring.

Go the extra mile

It is more than just performing duties, GRN24

Of all the enactments, only 'Non-*Care*' and '*Care* from within' was mentioned by more GRN. This was the only category on which I imposed my own wording. I took the concept of the 'extra mile' from the teachings of Jesus, who, when asked for a practical interpretation of loving your neighbour, told His disciples

that if asked to walk a mile with someone they were to go two, the extra mile. The concept of 'more than performing duties' comes from this perspective. There is a sense of spirituality from GRN 23 who uses the words to *daily give up something of themselves*.

And then, as if to reinforce its importance, the concept is mentioned again.

On my ward, in order to care it often means having to give up a little bit of reality in order to gain their trust and develop a rapport. Not always easy. GRN 23

Spirituality has become increasingly important in Holistic Care and in the literature on *Care* (Diers, 1997; Dossey, 1995; Dyson, Cobb, & Forman, 1997; Martsolf & Mickley, 1998; Saunders & Retsas, 1998). Watson (1985) identified the importance of bringing meaning to illness (and life) through addressing the second and last of the ten carative factors, naming them the Instillation of Faith-Hope and the Existential-Phenomenological Factor.

In Fosbinder's (1994) study of 40 patients' perceptions of nursing care, using a qualitative framework of observations and interviews, four factors of interpersonal competence of nurses were observed to be *Care*. These four competencies were deemed to be translating, getting to know you, establishing trust and going the extra mile. The interpretation of the extra mile was that the nurse was 'a friend' and provided care that was going beyond what was required. The concept of being a friend mirrors the travelling companion notion extrapolated by Campbell (Campbell, 1984). (Campbell is a lecturer in the department of Christian Ethics and Practical Theology in the University of Edinburgh, and his notion of moderated love is discussed in Chapter 2.) Fosbinder's (1994) concept of the extra mile is identified by the GRN in their reflections.

Pesut's (2002) study to elicit whether there was a link between the nursing school climate and the development of spirituality and *Care* was undertaken in the nursing school of a private Christian university. It found that the development of practical *Care* ideals between the first and final year students were primarily in the development of maturity. While the first year students were 'passionately caring', the fourth year students used terms such as 'real, transparent and honest' and were more willing to be involved with their patients (Pesut, 2002, p. 132). It was acknowledged that the limitation of the study was the Christian environment and I wondered about the importance of a nursing maturity. I have noticed that some of

our mature age students find the first two years of study difficult emotionally, and although they come with life experience, it is often not in nursing and they need to come to terms with the realities of nursing. Wright and Sayre-Adams (2000) conclude their preface with the injunction that there is a need to wake up to the fact that, "the sacred in health care, healing and caring is probably the greatest contribution that we can now make to health care" (p. viii).

The following two reflections do not have any connection to spirituality, but there is the quality of the extra mile.

Another way some of the nurses show they care is by doing little things for the patients that I have noticed some of the other nursing staff fail to do By 'little things' I'm talking about such things as trying to brighten up the patients room; taking the time to fix their hair, showing an interest in the photographs patients might have by their bedside. These 'little things' take no effort, but they seem to make a lot of difference to the patients. GRN43

The nurse took the time to sit and converse with the pt while eating therefore the pt ate. If the nurse hadn't cared she would not have sat with the pt and the pt would not have eaten. The pt was grateful and in good spirits. She responded in good spirits with that nurse. GRN34

Listens: the reflections

Listening, although second on the list of *Care* enactments, seemed by the tone and intensity of the reflections to be more important than going the extra mile. It was only the fact that the tables indicated a quantitative aspect to the enactments that the extra mile is listed first. Listening, it appeared, was not a simple hearing or part of a nursing action but a mastery of an everyday activity that was carried out with finesse. The action and the individual RN were always mentioned together and for this reason were also included in the first cluster. Listening and the *Care* RN became fused. Listening is not simply an act of hearing the patient: there was often a qualifier such as listening that was active, or that listening involved other actions that enabled the RN to interpret the needs of the patient as the listening involved reading the patient. It could well be argued that in some instances the RN was using intuition or discernment. The following excerpt in which the RN is said 'to read' the patient, could be interpreted as being 'intuition'. It is not. The context clearly indicates that it is a listening that also involves discernment.

….. as the nurse learns to read and identify how to comfort the patient. GRN 24

and then, as if to reinforce what is meant GRN 24 continues with a statement that a non-*Care* RN is one … *who doesn't listen to their pt. GRN 24*

The importance of communication is always addressed in undergraduate nursing programs so it was surprising that the identification was on a single part of communication and not on the importance of communication itself. Why was the listening aspect of communication so important in the reflections of the GRN?

The most caring nurse at the hospital listens, and has empathy. They are her 2 best skills and they show she cares. GRN 06

…displayed caring on many occasions most of which involved actively listening to patients' concerns. GRN 15

Taking the time to listen to patient's concerns and where possible and appropriate acting on their behalf to address their concerns. GRN 06

REFLECTION

I reflected on listening and came up with two concepts. The first was that listening is an important aspect of daily life. I expect people to listen to me. I expect students to listen to me. I expect them to follow instructions in a tutorial when we are doing group activities. In fact I get angry with students who do not listen to me. And even angrier when my husband or grandchildren do not listen. I found myself saying to a colleague recently, "No – listen". The second concept was the 'me' factor. People who do not listen are often selfish. They like to air their own opinions and are not prepared to listen to the 'other'. The more I reflected, the more important listening became. It seemed to be such a simple skill but not everyone listens. Patients know themselves best and know what they need, so, is it that nurses do not listen because we do not teach students to listen? I turned to the nursing literature.

Listens: the nursing literature

Searching the literature was not productive, in fact there seemed to be a negative aspect to listening. A summary of research by Fletcher in 1997 revealed

that in practice nurses' communication skills were weak. Cited research, from a number of sources, found that nurses avoided communicating with patients, preferring to keep communication to a task-oriented basis particularly with the elderly and racial minorities. The quoted research seen singly is sometimes dismissed or ignored but in concert reveals nursing does not always put the theory of good communication (including listening) into practice (Fletcher, 1997).

Fletcher's research may be dated, but a recent study of the management of postoperative pain in children indicated that one of the obstacles to good pain management was poor communication on the part of the RN (Simons & Robertson, 2002). This indicated that the indictment that Fletcher levels at RN on a practical level continues.

Two years after Fletcher's (1997) work, Lennart Frederiksson's (1999) Swedish research on the relationship between presence, touch and listening in a *Care* conversation revealed a singular lack of research in listening. There were only seven studies over a period of eight years on listening that were relevant to her research. Using a qualitative research synthesis model, each of the concepts of presence, touch and listening was explored. The qualitative research synthesis approach was extensive and thorough. Of interest here are the seven studies on listening (1990-June 1998), which were found to be the weakest theme in the three concepts. The important element of listening was found to be 'intentional' which involved more than hearing; being able to enter into the world of the patient and "allowing time and space for the patient to find their own interpretation of the experience." When this type of listening occurred the interaction was interpreted as being *Care* (Fredriksson, 1999, p. 1174).

In a recent publication by the same author (Fredriksson) and co-author Katie Eriksson, (2003) the ethics of *Care* communication was explored. The authors assert that communication in nursing has been reduced to techniques that can be easily learned, and refer to nursing communication as being a 'caring conversation'. The ethical focus of their writing is not applicable to this research. What is important is their interpretation of communicating as being "back to a concrete situation in which the practical wisdom of the nurse enables him or her to act respectfully and responsibly" in the giving of the self in the Christian tradition of caritas and the Good Samaritan (Fredriksson & Eriksson, 2003, p. 144).

On a practical level Ries (2003) interviewed a number of well-known physical therapists on the subject of Caring. Their comments are from experience as well as academic achievement (indicated by their qualifications – most with a PhD) and for the most part focus on communication. The comments were interesting and all focused on practical aspects of the art of listening which is to be able to really listen "aurally, visually, intuitively". They indicate that Caring conversations are "more a matter of focused attention than time" and that clients need to feel that they are being heard (Ries, 2003, pp. 37-43). Dossey (1995) proposes that there is a pseudo-listening that takes the place of real listening; clearly something that still occurs professionally and socially.

The interpretation of intentionality, as described by Fredriksson and Eriksson (2003), and the purely practical interventions by Ries (2003) are compatible. The 'intention' discussed by the Swedish writers (from the psyche or the heart) of the *Care* nurse in whatever situation they are in, should be one in which the good of the patient is dominant but at the same time the '*focused attention*' (purely a physical/mind concept – described by Ries) of conversation is required. It is here that one enters the realms of the philosophical and becomes at risk of being too theoretical. Notably Watson, in the area of *Care* theory, is using the concept of intentionality more frequently (Dreary, 2002; Watson, 1999, 2000). Unfortunately the practical interventions are for the most part excluded in favor of the theoretical assumptions; concepts that are often beyond the understanding of some undergraduate students with poor academic histories.

Beddoe (1999) describes *Care* (she does not use the word) as connecting with the patient in the "reachable moment" (p. 248). The strategies are the ones that could conceivably be part of good communication skills. The importances of being non-judgmental and fully accepting/respecting of the patient are strategies that are commonly found in texts on communication/listening skills. It is the second two skills that Beddoe lists "Let nothing matter but your patient" and "Be kind, but do your job" that command attention (Beddoe, 1999, p. 248). Rogers' unconditional positive regard and Mayeroff's element of 'courage' are clearly part of these two strategies (Mayeroff, 1971; Rogers, 1967; Rogers, 1980). The reachable moment is an echo of the *Care* moment described by Watson (Watson, 1998, 1999; M. J. Watson, 1996). The difference is that Beddoe writes that the strategies that she has used herself have enabled her to reach the moment of connectedness or *Care*. It is an

important concept borne out by the reflections as a way in which the RN enacted *Care*. In summary Suzanne Beddoe is advocating what may be termed focused listening.

Listening is, however, more than just being focused and is, and should be, a habit, something that is embodied in the daily lives of everyone, not only nurses. It is a mode of using the senses and movement together with "the habits of speech and thought" and to recognize that although these are part of the listeners' culture and own individuality, they are also "social sensibilities" (Jaeger, 2001, p. 138). By inference, the therapeutic relationship is one that is clinical, but the research of Cortis and Kendrick (2003) indicate that it should also incorporate the 'social' and is a skill that nurses should develop.

Over the past fifty years the patient has increasingly become the focus of subjective care. The subjectiveness of the patient puts the patient into a position of powerlessness. Nursing Diagnosis and the focus on becoming master of the increasing technology has moved the nurse away from the patient. This is contrary to the philosophy of Caring as espoused by Mayeroff, Heron, Rogers and the holistic nursing theorists and researchers – where the other (the patient) becomes the focus of growth and enrichment (Blattner, 1981; Heron, 1990; Mayeroff, 1971; Parse, 1981; Rogers, 1967; Rogers, 1980).

In reference to the turbulent times in which health care is practising, McCrea et al (2003) make the point that relationships are the key to quality and healing energy in nursing. Although the contention is made that there must be changes in the health care system, they assert the importance of listening and state that "The cornerstone of relationships is cemented in listening to each other" (McCrea et al., 2003, p. 241).

Gardner's (2001) research has already been referred to. It is important as it is an Australian study into *Care* and thus reflects, albeit a single study, an Australian background. Larson's Care-Q instrument was used and one of the findings was that the behaviour 'listens to the patient' was ranked third by patients and first by the RN as being the most important behaviour (Gardner et al., 2001). This correlates strongly with the results here that give the *Care* actions of listening second ranking. An important aspect of this result is that it is qualitative. The GRN (the co-participant researchers) were reflecting on *Care* incidents; in other words they were

watching and thinking about what was working in showing *Care*, and listening was the second most important.

Listens: my reflection

The reading of the literature and the importance of communication and listening set the scene for my reflection. I reflected on the results and decided that the GRN focus on listening was critical but wondered why it was so important and if the non-*Care* RN had in fact not listened. I asked myself if there was an element of 'not listening' that made listening so important. The theoretical communication lectures always include the importance of listening, but I wondered if listening takes a secondary place in the modelling/teaching of communication.

I then turned to reflect on my (and other lecturers) teaching of nursing practice skills. The first year student is taught to 'close the windows, screen the bed and tell the patient what you are going to do'. Something that is reinforced again and again. I wondered if I was part of the problem. It was perhaps a depersonalisation of the patient, part of the regimentation when bedpan rounds told female patients when they had to void. Nursing has moved beyond that regimentation, or has it? Some nursing home residents are still showered before morning tea. Holistic nursing and the nursing theories helped with the move from such approaches.

The average age of the RN population in Australia is increasing. The 'proportion … aged 45 years and over increased by 17 percentage points between 1987 and 2001' while the younger age group (under 34) decreased by 24 percentage points (Heath, 2002, p. 51). It is not difficult to conclude that the older RN trained in the 1970/80's, and by simple deduction realize that some of the RN used 'Doherty' as a text. (References has already been made to this fundamental textbook used for many years in Australia, *Modern Practical Nursing Procedures).* It does not refer in any way to the importance of communication. The inference is that the nurse, especially the junior nurse, needs to be respectful to senior staff and doctors and clearly states that "Junior Nurses are expected to see that the near relatives sitting with very ill or dying patients are given every consideration and some refreshment supplied as required." It was a focus on the behaviour. Further, the text admonishes the student that the ordinary "politenesses" of life are to be observed and "discretion should be exercised in private conversation" (Doherty, Sirl, & Ring, 1954, p. 4).

Although the concept of open communication is now well established, some of those who 'trained' under this philosophy maintain the 'discretion', and patient and family communication still takes place on this level.

'Murray' (1976) is an example of the new era texts. Slightly larger with fewer pages and bigger print with attractive black and white photographs, the emphasis has changed dramatically from the staid format of 'Doherty Searle and Ring'. The text stresses the importance of the 'whole patient' and the inclusion of the whole family as well as the significance of good communication skills. It was the age of the Nursing Process and the importance of planning care, and the focus is, ostensibly, on the patient. The application of the nursing process is summed up as follows

> The framework of a nursing care plan is based on information about why a person needs care and *judgments made about what kind of care he needs*. (Murray, 1976, p. 55). (Emphasis mine)

The patient is very much the 'subject' of care. Indeed the subjectivity of the patient is apparent in both texts. Murray was not used as widely or as long as Modern Practical Nursing Procedures (Doherty et al., 1954) but its use spanned a number of years. It was during the late 1970's when Murray was published that the market must have been perceived as being lucrative as a number of other fundamental texts were published. The importance of holistic nursing and communication became more important. But at this time the texts became longer and more detailed, possibly not read as the authors (or the nurse tutors and now lecturers) intended.

I looked in vain for something to substantiate my thoughts. Eventually I found something from the eminent researcher on *Care* (and other areas) Janice Morse. The only reference that could be found was a brief sentence in her 1992 research on comfort. Some of the methods in which comfort is given are noted, and research into the "therapeutic effectiveness" of nursing needs to be further researched and "the practice manuals and nursing theory must be re-examined" (Morse, 1992, p. 4).

Puts patients at ease

The 'put patients at ease' topic was missed at first. I remember noticing it and dismissing it as being a once off comment. It was therefore surprising when in one of the cycles of the reflections I found it again and searched for repetitions of the concept. These were part of a very early list of actions that were brought together to form the 'ease' topic. It was GRN 24 whose reflection alerted me to the concept.

Caring is an art because it is about creativity making a pt feel at ease in a strange new environment tuning into their wants/needs, reading their mannerisms (those of the patients). It is more than just performing duties, its about doing things for pts in a way that makes them feel comfortable. GRN 24

There were twelve other GRN who mentioned this factor, naming it differently -'reassurance' 'relax' 'calm' and 'relieving the distress of a patient'. Gardner's quantitative Australian study on *Care* referred to previously indicates that patients want safe care. Gardner found that patients rated safety in care (how to give injections or manage Intra Venous therapy) as the primary factor in *Care* (Gardner et al., 2001). There is a central issue here that the GRN has elicited. The links between being at ease and putting oneself into the care of another, a stranger – the nurse, is complex but understandable.

REFLECTION

> If the *Care* action that put the patient at ease was so important, what does this ease mean? The nursing literature did not help. I then considered the social skill of entertaining and wondered if there was a correlation. I believe there is. The hospital is for many patients and their families a hostile and frightening place. A hospital for many nurses is their work place, a warm friendly environment where for many there are long-term working relationships or a place of intense interest in a life-long career. Patients and families see a hospital differently. Nurses are the hosts and hostesses, and those with the social graces that are able to welcome the patients as guests and put them at their ease are perceived as being *Care*.

'Manners' was only mentioned once and was incorporated into the topic of ease. Wright and Leahy devote two pages to discussing the importance of manners

in interviewing and assessing families. The point is made that nurses have taken on the relaxed social attitudes in society and that in a professional relationship good manners are a significant way to the beginning of a trusting relationship. "Manners are those simple but profound courteous acts of politeness, respect, and kindness" (L. M. Wright & Leahey, 2000, p. 277). The essence of this definition is spelt out in a reflection on a dying patient and a cup of tea.

GRN 49, in an incident where a patient in intensive care is not expected to survive, tells how the family is informed of the situation and then says; *Simple gestures like bringing a cup of tea to the family* were viewed as being *Care*. The link between the telling of devastating news to the family and the social grace of a cup of tea is important. It indicates that part of the *Care* enactment/strategies/skills is an ability to manage/integrate basic interpersonal social skills with professional expertise in what was conveyed in the reflection as being done with effortless ease.

Touch: the reflections

It was not surprising to find touch being an important part of *Care* enactments. It is the most basic form of communication and the first communications of which infants are aware. The soothing cuddles of early childhood, translated into a hand been held or a reassuring touch on the shoulder are still needed in times of adult crises. Most patients instinctively need/want a supportive touch or a hand to be held in moments of apprehension about the future or what is happening to them at the time.

Almost half of the reflections mentioned touch as being important. Significantly, handholding was mentioned by one third of the GRN. It is interesting to note that GRN 8 has thought about the concept of touch and its relationship to *Care* and also notes that *Care* enactments should be part of a job description.

Basic gestures such as offering a hug, a hand or retrieving an extra blanket tend to make caring RN's easy to identify. Caring generally seems to require an action that is not necessarily in the job description. It is difficult to tell whether patients respond to such signals in a positive way. That is, it is not possible for me to tell whether patients believe that such acts are caring or whether a requirement of the job. However it can be observed that by simply holding a patients hand, that patient derives reassurance. GRN 8

And for GRN 23 a powerful learning experience.

I found a lady patient hidden around a corner, crying. I sat beside and said nothing. A while later she settled and we started talking. The voices in her head were telling her to kill herself and her child. The woman then became very emotional, screaming she didn't want to do it and couldn't understand why she would think that way. I gave PRN Diazepam called the psychiatric Registrar. And led the women to her room. I stayed with her, not talking just holding her hand and giving her tissues as I didn't know what to say or what else to do. The psych. Reg. came and talked to her and afterwards (with the help of Diazepam) she settled and went to sleep. I felt like a failure afterwards. Why couldn't I say something that would have helped her I felt stupid, dumb and a complete idiot. The women came up to me later and said 'thank-you'. People usually try to talk me through but it doesn't help. Thank-you for just holding my hand. I couldn't think for a while after that. I was stunned. I had just held her hand. And then I thought of the old adage (only modified)

if you've got nothing to say, then don't say anything.

With all the emphasis being on talking I had forgotten the most basic. Touch. GRN 23

There were links between listening and touch. It was a learning experience for the GRN in that touch had been noticed as a *Care* action, the GRN then used touch as a caring technique.

The RN I worked with for the first 2 weeks showed caring by touch, GRN 32

The nurse seemed to sense what each individual needed from her. Simply taking hold of the offered by the pt and silently sitting with the patient demonstrated that the nurse truly cared. Taking time to sit with pt's is important in caring for patients and their families. GRN 34

Touch and observation were two very vital components I saw in caring, knowing when a patient needs "touch care" is important and being observant of changes in mood. GRN 39

Secondly I have observed and analysed care this week. I have found that touch is a large component of care. When patients have been in pain, anxious, upset or extremely ill. Reassurance to patients is somehow not

quite as powerful as touch. For example holding someone's hand, a hand on the shoulder, or stroking someones back has shown to be much more powerful than words. Often it has been quite awhile since the patient was last touched. Taking the time to talk to someone should not be excluded but surely is not as direct in its message as touch. GRN 48

REFLECTION

I wondered why GRN 23 had forgotten about touch and where in the curriculum the theory of touch had been taught. I could not come up with an answer. I wondered at the way in which the concept of touch had been described and came to the conclusion that one of the reasons the GRN had focussed on touch was because it was for them a new concept. I also reflected on the value of the reflections to the GRN themselves and decided that it had been a valuable exercise. There was an underlying message that in the reflecting they themselves had learned.

Touch: in the nursing literature

The literature delineates different kinds of touch and is highly theoretical about this simple gesture of *Care* that was observed as being important by half the GRN. Ching (1993) identifies five kinds of touch: functional, affectional, protective, therapeutic and an extended form of touch, massage. The focus is on therapeutic touch. As novice nurses, the GRN were perceptive enough to identify different types of touch as *Care* enactments, comfort, therapeutic and the power of a reassuring touch were identified. A young child's neck was stroked in a comforting gesture, and GRN 23 was 'stunned' by the therapeutic gesture of simply holding a patients hand, while *GRN 48* (quoted above) notes that *Reassurance to patients is somehow not quite as powerful as touch. GRN 48*

I returned to Jocelyn Lawler's (1991) treatise on somology. The touch in Lawler's context is how nurses cope with the physical touching that is required in nursing. "Nurses, therefore, must negotiate the cultural and status-bound aspects of social relations when they touch patients" and "touching patients requires a particular manner and context to ensure that the act of touch is not misinterpreted" (Lawler, 1991, pp. 110-111). The links between touch, comfort and presence are interesting and are commonly treated separately in the nursing literature. However Frederiksson

(1999) links touch, listening and presence in an analysis of the research on these topics, and entitles the article *Modes of relating in a caring conversation: a research synthesis on presence, touch and listening* and notes that the literature identifies two types of communicative touch, caring and protective. It is of significance that "task-orientated touch to some extent always carries a message", (Fredriksson, 1999, p. 1172) perhaps echoing Lawler's injunction that there is a need to ensure that the task oriented touch is not 'misinterpreted'. Bottorff (1995) explicates touch as an aspect of comforting, and delineates two kinds of touch, comforting and connecting touch. The importance of a synergy of the responses (found in their research) to "create a positive atmosphere in which patients *felt at ease* in discussing difficult issues" is stressed (Borttorff, 1995, p. 1082) (Italics mine). Importantly, the touch elicited in this research is also connected to the concept of being able to put patients at their ease. It is possibly a fruitful area for further research.

Defining comfort is as elusive as defining *Care*, due mainly to its subjective nature. It is the patient who is in need of comfort and therefore the patient is the only one who can objectively say whether or not they have received comfort. Morse (1992) takes this concept one step further and argues that the concept of care is nurse focused but comfort is patient focused. This concept seems not to have been taken up by the nursing researchers, who, for the most part, focus on the nurse. Morse (Morse, 1992) gives three components of comfort – touch, talking and listening. Touch and listening are confirmed by this research as being two of the most important *Care* skills.

This is primarily because of the different ways that *Care*, comfort and touch are defined. The different kinds of touch have become thorny because of the recent emphasis on Therapeutic Touch (strategies of Holistic Nursing and alternative therapies) as well as the need to be mindful of the law and touching that could be interpreted as being unnecessary and therefore battery.

I returned to my reflection above and decided that I had not addressed the topic. It was an omission on my part. *Care* touch was/is important. It was months after I had written the above reflection that I reread the research done by Estabrooks and Morse (1992). Using a grounded theory with eight intensive care nurses, the study sought to find how intensive care nurses learned to touch. The study found that the nurses did not recall any specific or non-specific learning about touch during their nursing school education. They also indicated that they felt that there should

have been some structured learning about touch. It was during the time in intensive care that there was an 'intense learning about touch specific to nursing' (Estabrooks & Morse, 1992, p. 452). Informally, as I reflected and as I interpreted the reflections, I had come to the same conclusion. I reflected on the importance of the synergy of the enactments and the recent brush with nurses that Jen, our daughter, had had. The details are immaterial. What is significant is her story of her admission and first few hours in hospital – a disaster (for her) – and her story to me,

> …and I felt so stupid and kept on crying and the RN was doing what she must have felt was the right *Care* thing to do. She kept on saying that she understood and kept on stroking my knee and all I wanted to do, and I couldn't because I was crying, was to shout at her and tell her to keep her hand off my leg and listen to me.

The RN had listened, empathized and touched BUT had <u>not</u> listened and touched appropriately. It is a salutary lesson in Non-*Care*.

Active interest

In one reflection there are three incidents of *Care* described. There is no indication that it is in reference to a single RN, and the incidents in themselves were 'ordinary'. A patient was taken for a walk, classical music was found for a patient, and make-up applied to a patient who had suffered a stroke. GRN 15 sums up the intent of the enactment/strategies/skills in a summary statement at the end of the reflection, which in essence explains why the three incidents were chosen. It is the reason why this enactment was named active interest.

… a few nurses obviously took an active interest in their patient as they were able to discuss their home environment and discuss both the patient's and the relative's concerns. GRN 15

At times active interest was just as *Care* to do nothing …the *Care* RN allowed the relatives and patients *… space and leave them be. GRN 32* And on a very ordinary level GRN 6 noticed that it was in the ordinary of nursing that she/he and the patients noted the *Care* actions of the RN.

Providing basic personal care without being asked – ensuring bedfast men have a clean urine bottle, ensuring privacy at all times, making sure that the patient has everything they need in reach. GRN 06

While GRN 06 reflection is about what is commonly called basic nursing care, it has been specifically linked to *Care* and could not be put into any other category. These actions were in essence what nurses do or should do routinely, and are part of the 'everydayness' of nursing reflected in the stories of *Care* in 'thriving technology' (Arndt, 1992) or part of the 'ordinariness' of nursing (Taylor, 1994).

One of the reflections encapsulates the therapeutic relationship. GRN 15 finishes the last reflection by saying that at times GRN 15 has felt both 'inadequate' and 'stupid'. But, there has been *Care* shown to her during the weeks that the reflections had been written. As a result of this GRN 15 concludes by saying that,

Being accepted faults and all by others, thus being accepted as an individual is to me an important aspect of caring. GRN 15

The other RN in the ward have in essence shown an active interest in the GRN as a person. This is the 'unconditional positive regard' of Rogers (C. Rogers, 1967) as well as an insight into the GRN. This GRN has been able to identify their own feelings as well as the way that they can care for others. In a single sentence the essence of what Carper (1978) calls personal knowledge is summarised. Carper's seminal article on the patterns of knowing in nursing is widely quoted and it was amongst my early readings. I revisited the article and a number of concepts suddenly became clear. Carper deals with four kinds of knowledge but concludes by emphasizing that they are not 'mutually exclusive'. Dealing with personal knowledge in nursing, the point is made that the patient cannot be known unless the nurse has self-knowledge with an ability to recognize the uniqueness of the patient (Carper, 1978). This is an interesting concept and written prior to the commencement of nursing's interest in *Care* and the notion of emotional intelligence, inherent in which is the concept of self-knowledge (Goleman, 1996a, 1996b; Salovey & Meyer, 1998).

Respectful of family

Family are mentioned time and time again and always in relation the *Care* nurse. It is not a skill in itself, but the way that the family is included as part of the patient is important in the *Care* incidents. A phenomenological study of Intensive

Care nurses and their views on *Care* revealed that "encountering positive patient and family interaction", and sometimes allowing extended visiting hours, were fundamental to *Care* (Barr & Bush, 1998). One of the GRN tells of a personal encounter with the family and how the visiting hours were changed by

…allowing a husband to see his wife after visiting hours (something I loosely believe in). He knew that I understood that he worked long hours - nurses need to care for families. GRN 39

In research on families of patients in emergency departments or intensive care units, Washington (2001) makes the statement that the family that feels cared for "can potentially help the patient's psychological and physical status" (p. 37). A second study of note is the research in Japan with ten families where the wife-mother had been diagnosed with breast cancer. Visiting nurses met with families to assist in constructing patterns of family dynamics as a nursing intervention and by establishing *Care* between the family members themselves. In as few as two interviews the family (the patient included) was assisted in coping with cancer symptoms and rising to a 'transforming vision' of Caring. Although the study was specifically aimed at clinical interventions with the families, there is an importance in assisting the families to "recognise their own power" and the power of *Care* (Endo et al., 2000, p. 609). The importance of the family and their recognition by the GRN group on a formal level in the *Care* process was recognised.

Participatory Dialogue: the reflections become a reality

The final evolving episode of Phase I still needed to be completed. Participatory dialogue is part of the evolving cycles as a check on the researcher and co-researchers and the way that the results have been interpreted. The focus remained on the first research question, the *Care* enactments. As outlined in Chapter 4, an invitation was extended to the GRN participants to participate in a Participatory Dialogue at our home. Six of the GRN attended the day. The purpose of the day was twofold. The GRN were to firstly reflect on the analysis/interpretation of the reflections (a preliminary summary of the findings was posted to the participants for careful reading). Secondly there would be a collaborative discussion on the findings in a relaxed atmosphere. Notes were taken, transcribed and sent to the participants for verification.

The silent voices of the GRN suddenly became a reality. It was a cool winter day with the warmth of the potbelly stove matching the conviviality of past students sharing their experiences and what their GRN colleagues had written in the reflections. There was a sense of relief as they read the transcription and discovered that what they had written 'matched' the other reflections. It was a day of contrasts. The discussions ranged from being affirming and angry, supportive and surprised, and finally endorsing and enjoying the experience.

- Affirming that the reflections really reflected reality.
  Angry, that some colleagues had not been supported.
- Supportive of each other as other stories of *Care* and non-*Care* were told.
  Surprised that their experiences were all so similar.
- Endorsing the future and the research.
  Enjoying the dialogue, even though they did not really know each other.

The discussion centered on holistic *Care*/nursing, needs and wants, preferences (nurses do 'well' in some areas and not 'well' in others) and the fact that there was little support in the Graduate Nurse Programs. The discussion took an interesting turn when the concept of remembering was raised. There was consensus on the notion of good communication, but there was a further important aspect, remembering. There were four participants who were in areas where there was a high readmission rate. It was not possible to remember patient names but the little things that were unique to the family would suddenly surface in their memory and they would be able to 'reconnect' with the patient in being able to recall a particular concern or topic. There was total consensus on the importance of 'little things'. The significance of this is that after six months in the workforce they were cognizant of the importance of the uniqueness of the patients and their families.

At the end of the discussion the participants were asked if their views of *Care* had changed since sending in the reflections four months previously. I quote from the transcript,

> Participants in general discussion indicated that, looking back at their initial responses to the study, they were over critical of the RN that did not enact *Care* and also focused on trying to cope with being new RNs although they

did see some *Care* RNs. They also generally agreed that they realized now that they can be specifically *Care* in the little things that they do for patient care that make a difference to the patient's stay in hospital.

In essence there was total agreement on the concepts of listening and reading the patient, being professional, holistic nursing and the importance of the team. 'Touch' was a concept on the preparatory material that was sent out but time ran out and the concept was not discussed.

The transcript of the discussions was subsequently sent out to the participants for verification of the accuracy of the recording of the day's events. I decided to ask a final question at the end of the transcript.

"If we had the day again would you be saying the same things? Yes/No."

All the returned transcripts replied in the affirmative. Two GRN added comments.

(Although I knew who the GRN were the replies were anonymous. As a result the following two comments do not have the usual GRN number identification.)

One GRN noted that

Even more so now I can identify 'caring' nurses-it shows in their attitude-that patients are treated as people with all the added 'baggage' that comes with life-their issues, concerns, likes, dislikes, families and partners" and that "patients can identify these qualities.

The second GRN wrote at some length, discussing the emotional link that a RN has with a patient that can and should occur for just a single shift. This emotional link was described as*…being in sync with the client anticipating their needs their wants, being empathetic*

Conclusion

I considered again that the GRN, as co-researchers, could have had greater contact with me. The informal contact with the GRN over the past few years has been interesting. As co-researchers they are always intensely interested in my progress and what I have found in the analyses and interpretation. It appeared that the reflections made an impact on their clinical lives and hopefully on their patients

as well. I regretted that I had not planned further formal contact with them. At the time the distance of the rural university and my home to some of the city and remote placements of the GRN made more contact difficult and in some cases impossible. Be that as it may, it would have been profitable to have had more formal contact with the GRN as the research progressed.

I was aware that there is an inherent danger in quantitative measures of *Care* as *Care* itself does not have a universally accepted definition in nursing yet its importance is fundamental. Beck (1999) argues forcefully that the measurement of effective *Care* and quality care is central to nursing and how this measurement can be done is still not clear nor has it been successfully achieved. I could clearly not depend on numbers and categories.

Listening is definitely a skill and I wondered why it was that the group as a whole had zeroed in on what I called only a part of communication. Touch in turn, also very definitely a skill, was something that I could not remember as being part of any of the units/courses that I had taught. It seemed as if it was a skill that had not been considered. I was very much aware that one of the final units/courses that the group had done included law and the concept of consent and battery were emphasized. Asking permission to intrude into patients' personal space was important. Was there a link here? Did the RN do the touching so naturally that it was known that the patient needed touch and there was no need to ask permission? Was this in essence a personalization of patient care? If it was, what was the skill, if any, that was needed to *Care*?

Care is a matrix of responses to unspoken and often unfelt needs for *Care* within the health care system. As the need originates in the patient, the nurse's response is often intuitive to a unique message that the patient is sending. This is done by a combination of the ten *Care* actions and personal characteristics elicited by this research.

The synergy was there but at this stage could not be rationalized or simplified into a teaching framework. The findings were clear but there were too many pieces. There were two clear areas, four characteristics of the RN that could not be taught and six enactments. Two of these enactments, listening and touch, were clearly ones that needed emphasis in teaching *Care*. The other four, although specific in their own right, were possibly too nebulous to teach. I needed an overarching concept that would cover the four enactments/strategies/skills of going the extra mile, putting

patients at their ease, taking an active interest in the patient and being respectful of families.

Themes extracted from the reflections of two groups of senior nursing students about the *Care* behaviours of their preceptors yielded similar results to this research. Patton's (1995) study of the *Care* behaviours evidenced by preceptors classified the behaviours as, Active/authentic presence (half the student group mentioned this behaviour), Competence, Way of being, and finally Emotional support for the senior nursing students. Two sub themes of touch and care of the self were also noted (Patton & Woods, 1995). The phrases quoted in Patton's study were in many respects remarkably similar to the phrases used by the GRN.

I returned to Farmer's (1992) 'patterns of interaction'. I needed a metaphor to explain the 'patterns'. A kaleidoscope seemed appropriate. There are only a limited number of pieces in a kaleidoscope but the patterns that are seen as the scope is held up to the light are numerous. So too with the patterns of *Care*. A limited number of actions played out in the infinite variations of personalities (nurse, patient and family) and environments give beautiful patterns of *Care*. I wondered about the notion of reinterpreting *Care*.

Phase II and the generation of a teaching framework and the meeting with the experts was the next cycle in the research. I turned to my next challenge.

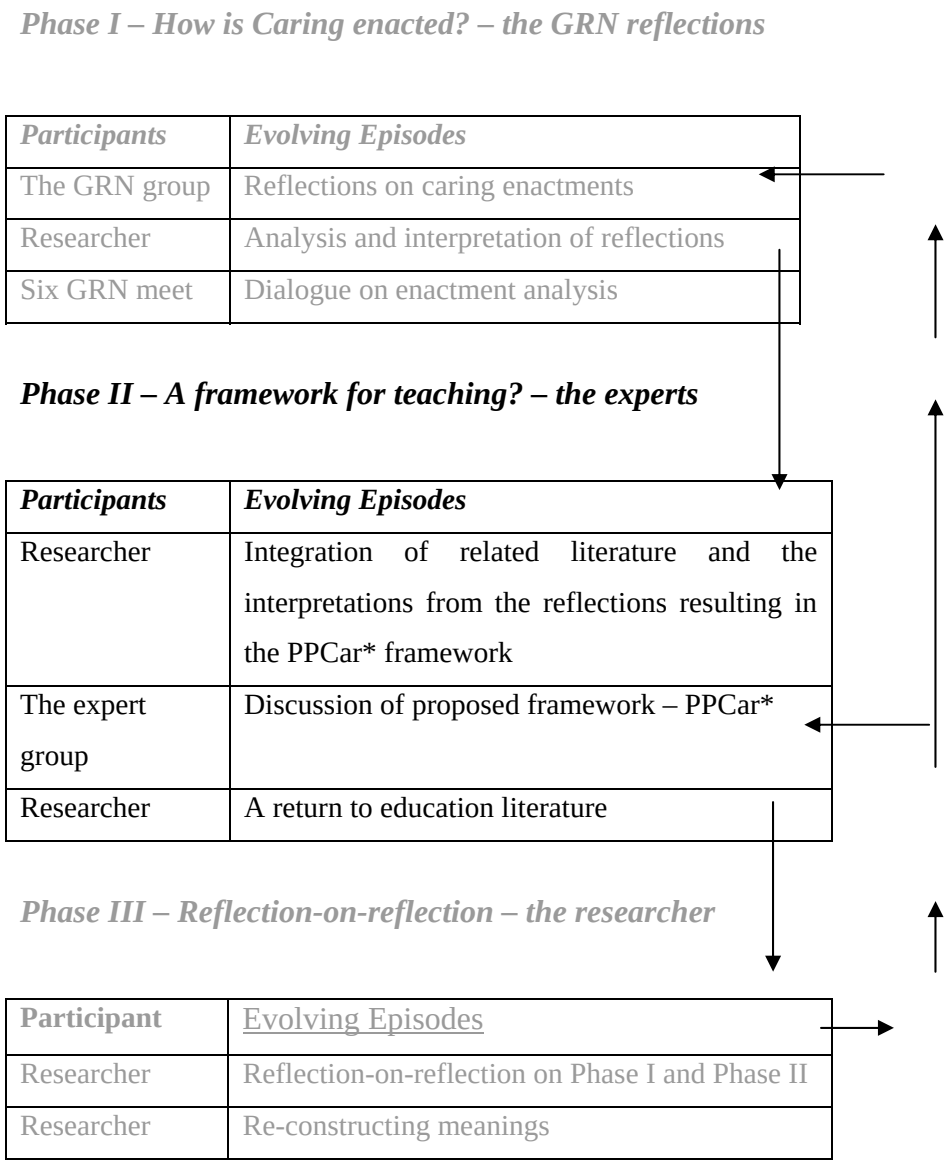
Chapter 6: Phase II – A Framework for Teaching?

Chapter 6 addresses the second question of this research:

- How can the findings of the research and the literature be synthesized into a framework for teaching *Care* strategies?

Phase II takes the six enactments, plus themes from the literature review and the concept of the *Care* RN, and incorporates them into a framework for teaching *Care*. The primary objective in the synthesizing of the themes is to bring a practical focus to the teaching of *Care* in undergraduate nursing programs. The separate phases of this research inform and interact with each other in keeping with the circular processes of participatory research. The possibilities of the *Care* framework were already germinating in Phase I. The insights thus gained were used to generate unified concepts, and a suggested framework – Personalising care in order to give Professional *Care* (PPCar*). A small group of experts met to discuss PPCar* and made a number of recommendations. As these were pursued, further insight into the framework led into the final cycle of the research in Phase III. In keeping with the cyclical nature of the research process, Figure 6.1 indicates that all three Phases are still present, but the focus is on Phase II, while Phases I and III pale into the background.

Figure 6.1 A three phase cyclical process



Introduction

The second question, as follow-on to the first question, seeks a teaching framework that could be used in undergraduate nursing programs.

The three evolving episodes in this phase of the research involved the researcher formulating the framework, the group of experts in education who came together to critique/discuss and formally evaluate the teaching framework, and finally, further exploration of selected literature. The framework was called PPCar*, an acronym indicating that Caring in nursing could be taught and then given using Professional Personalised *Care*. The *Care* enactments elicited from the reflections of the participant researchers, the GRN, as well as concepts from literature review, were incorporated into PPCar*.

The framework as presented was in a stage of development; an evolving and maturing of the concepts that were to lead to the final *Care* framework. One of the key factors in participatory research is the fact that it is evolving and "celebrates participation and democracy" and "honours a holistic perspective" (2000). Arising from the discussion with the experts, further reading on curriculum development, setting of objectives and investigating specific research on the teaching of *Care* was undertaken. In keeping with the collaborative inquiry philosophy, the researcher then concluded Phase II with a reflection on past and present experience in teaching undergraduate nursing students. This reflected the philosophical assertion that "Proposition(s) about human experience are of questionable validity if they are not grounded in the researchers own experience" (Bray et al., 2000, p. 4).

Creating the teaching framework

The first of the evolving episodes involved the creation of the framework. The generation of a framework to teach the practicalities of *Care* was in answer to the second question in this research. The compilation of the critical enactments that had been culled from the GRN reflections, and an incorporation of the concepts from the literature review into a framework, seemed to be a simple process. It was an exciting and evolving progression as the concepts were taken into a plethora of arrangements and designs.

The primary rationale for the framework was that it could be used as a base for teaching undergraduate nursing students. Two important factors had emerged

from the research and my reflexivity as the research progressed. These factors were additional influences in the structuring of the framework, and were part of the development process, and will be discussed briefly prior to the précis of the PPCar* framework. In the first instance, I came to the conclusion that the climate in which *Care* would be enacted significantly affected what was taught. It was possibly a theory/practice issue that needed to be considered. I was mindful of the fact that the current climate of health care is dynamic, pressurised, and under constant change. The framework would therefore, of necessity, need to be a practical one that could be actually used in the clinical setting. Secondly, the student factor was becoming an increasingly important one. The students themselves, the recipients of the teaching and the workforce for possibly the next forty years, needed to be taken into account. In considering these two factors, I felt that they profoundly impacted on each other as well as the format of the framework of teaching.

Factors influencing the genesis of the framework

The current climate of health care

The first influence – the current climate of health care – is discussed in the literature review. What must be reiterated here is the fact that being a *Care* RN under these circumstances is not always easy. The need for a practical interpretation of *Care* was evident.

There were two sides to the current climate that would need to be taken into consideration. In the first place, it is a system in constant change, and under pressure to do more with less, often with sicker patients. I argue that there is little time to get to know the patient, even on a superficial basis, and therefore strategies needed to be in place that would assist in development of a *Care* attitude. The other factor is that patients have a greater awareness of service. The patients are also customers or clients and often include families, demand a professional who is able to tune into the patient's needs and is also Caring. The point needs to be made that GRN 14 reflected that some patients also demand 'wants' and not only needs, commenting that, *Some patients even make this worse by taking advantage of the caring. GRN 14* I posit that in essence it is the patient (in their ego-centric illness state) who makes the decision or perceives the <u>care</u> as being *Care*, whether the nurse is inherently Caring or not.

The diversity of students

The second influence is the diversity of students entering nursing. It was a factor that I was aware of but it was also something that I had taken for granted – part of the ongoing professionalisation of nursing. Considering the history of nursing in my readings and analysing the implications had pulled me up as I looked at the student mix with fresh eyes.

In the past, most hospitals took a pride in the Caring young ladies who entered their nursing courses. They, the prospective nurses, were all interviewed, to ensure that the right student nurse was given a place in the hospital. This emphasis on Caring applicants continued into the early years of the transfer of nurse education to the tertiary sector. Currently, all nursing education programs in Australia use a computerised admission system to select students, as nursing departments believe that this fits in with the entry systems of all other university programs. Whereas this is not problematic in terms of equity in admission procedures, there are students who enter nursing simply to get into a university program or to gain the prospect of permanent employment and a good salary (Robertson, 1989).

Whilst fewer of the nursing students of the Twenty-first Century will have a true historical vocation to nurse, the mix of innately Caring students and others is an unknown. Those who do not have an innate Caring nature that will enable them to give the *Care* care described in much of the *Care* literature – and expected by many patients and families – will need the tools to enable them to give, in some way, expected *Care*. The inherently Caring students entering nursing programs will need to be given the tools to enhance their innate caring abilities so that the Care they give is a professional Caring related to Twenty-first Century *Care*. In the second place they need to be able to translate that Care into a professional *Care*. A further subsidiary issue in Australia is the range of academic ability in the student intake.

Hammer contends that there is a wide range of academic ability in university student cohorts, with an apparent need simply to get a professional certificate in order to start working and start living (Hammer, Norton, & Star, 2004). This is also reflected in students in nursing (Heath, 2002). The mix is wide and likely to remain so and it clearly varies from university to university. The range in the university where I work is possibly typical of the student mix at any rural university across Australia. There are the mature-age students of 35+ who left school in Year 9 and

have not studied since, except to complete a semester of part-time preparation to study. At the other end of the scale is the exceptional 17 year old who has completed high school with an academic record of high distinction. The majority fall in between; on average two-thirds of the entrants have run-of-the-mill school-leaving scores. Statistics also indicate that there are many students who are the first in the family to enter university. Many of these students will make competent *Care* RN but need help along the way to their registration. The framework needed to be comprehensive enough to satisfy the academic and professional requirements and also be adaptable enough for lecturers to use the framework to suit themselves and their particular student population.

Universities espouse the notion of teaching excellence. It is well to remember Ramsden's (1995) injunction that the fundamental importance of good teaching is to be able to find out where students are in their level of learning and then to decide where the profession wants them to be. "The growing numbers of students entering higher education without traditional sixth form qualifications imply that increasing attention will have to be paid to studying the variety of understandings and skills with which students begin a course of higher education" (p. 137). The importance of the dollar and the implications of filling the required number of student places on offer seems at times to be more important than the students themselves.

The teaching framework was formally labelled the PPCar* framework. The following should be noted. Other methodologies and methods would probably omit this Phase from the dissertation. However a participatory philosophy and an evolving of the processes in the research are innate in Collaborative Inquiry. *Thus the evolution of the framework is as important as the final framework itself.*

Two weeks before the meeting to discuss the PPCar*, details of the teaching framework were sent to the second group of participants, the expert group. The experts were able to see aspects of the framework from two perspectives. In the first place, they were able to view the work with unsullied vision and they would also see the framework in perspective, relating it to reality as well as to their past experience. They also had the ability to visualize how the framework could be implemented in the future.

Although the details of the PPCar* framework as given to the Expert group are in Appendix 2, a précis is given here.

A précis of the PP*Care* framework

The conceptual framework was named the PPCar* Framework. This framework is defined as being *Care* that is both Professional (in knowledge and in demeanour) and care that is Personalised (according to the implicit and explicit needs of the patient), underpinned by a philosophical interpretation of *Care* theory. It is a framework to be used as a module/unit/course in the teaching of *Care* to undergraduate students in nursing programs. In this original form it is a framework that uses the content derived from the reflections, the process of the literature review, and my reflexivity which was influenced by the course requirements of the university at which I am teaching. The reflections yielded two important perspectives on *Care*. The first, the simple enactments that were actually done, was the straightforward answer to the first research question, "what are the *Care* enactments". The second was the inability to separate the *Care* enactments from the Caring RN. It was thus imperative to use both these perspectives in the framework. The structure of the framework is given first. This is followed by the philosophical concepts used in the framework.

Structure

The PPCar* framework is divided into three constructs. These have deliberately been labelled 'constructs' as this does not limit the way in which the framework is utilised. These constructs can be used as modules in courses, complete/separate stand-alone courses or used to structure a series of lectures and tutorials. The structure incorporated only the theory with the practical application a separate entity (Figure 6.1).

The framework had been formulated with the following in mind.

- The PPCar* framework contains philosophies that will allow individual lecturers the academic freedom to select some of the content to suit their own creativity/style of teaching.
- The two levels of *Care* incorporate the practical aspects of *Care*.
- The cultivation of a professional environment would need to be fostered in the overall undergraduate nursing program. It is thus the context of the

program that helps to prepare the student to practice professional behaviour throughout a nurse education program.

Figure 6 2 Structure of the PPCar*

Professional Personalised *Care* (PPCar*)

Constructs	***Focus and Content***	***Supporting philosophies***
I ***Professional Care***	Assimilation of the essentials of the nursing profession • Codes of conduct, ethics • ANCI competencies • Reflective practice	Campbell 1984 Peck 1988, 1990
II ***Personalising care***	Developing skills related to emotional competency: • Unconditional positive regard • The *Care* enactments	Watson 1994, 1995. Rogers 1967, 1980 Goleman 1996
III ***Transpersonal Care***	Theoretical aspects of caring • The philosophy of Caring • *Care* theories	Mayeroff 1971 Nouwen 1989, 1992 Lewis 1998 Watson 2002, 2005

Construct I – Professional *Care*

Concepts of defining a profession and an analysis of professional behaviour and responsibilities generically, as well as specifically to nursing, would be introduced at an early stage of the undergraduate program. The national competencies and codes of conduct and ethics in nursing would also be addressed.

Construct II – Personalising *Care*

Listening/discernment is the art of being able to become aware of the patient's needs, and then being able to use the *Care* enactments of touch, being respectful to the family, going the extra mile, being able to put patients at their ease

and taking an active interest. These *Care* enactments had come from the analysis of the data. The information from the literature would be an ongoing emphasis on the development of emotional and social competence in the undergraduate student. This would be aligned with a beginning ability to focus on the patient using unconditional positive regard.

Construct III – Transpersonal *Care*

The focus is on an understanding of the philosophical concept of *Care*. The introductions to philosophical and nursing theories on *Care* are shaped/created to suit the needs of the cohort of students.

Supporting philosophies

The supporting philosophies were discussed in detail in the literature review (Chapter 2) and are thus not discussed in detail here.

Watson's early work of 'being' is one that is understandable and teachable for beginning students. Using Watson's early theory allows students to further explore her work and understand the sequencing and development of the later concepts (Watson, 1985, 1989a, 1989b, 1998, 1999, 2000; Watson & Smith, 2002).

Mayeroff's (1971) position on caring, being the 'growth of the other', is essential to the concept of his eight ingredients of caring. These are bound up in the notion of 'tough love' that is experienced by parents as they seek in love to lead their children through adolescence to adulthood.

Also included are the concepts of moderated love as a professional construct (Campbell, 1984), maintaining soft boundaries (Scott Peck, 1988, 1990), unconditional positive regard (Rogers, 1967; Rogers, 1980) and theories from philosophers such as Nouwen and Lewis (Lewis, 1998; Nouwen, 1989; Nouwen, 1979; Nouwen, 1992).

The concept of emotional intelligence, as first enunciated by Salovey and Mayer, and later popularized by Goleman as emotional competence, is used to underpin the concept of being able to develop a Caring attitude (Goleman, 1999; Salovey & Meyer, 1998). The notion of the student nurse having the emotional competence to deliver *Care* is counter to the philosophy that *Care* is a sacred entity and the entry into nursing was and sometimes is vocationally inspired. Although the

constructs of social and emotional competence and emotional intelligence are relatively new, they have not been widely taken up by the *Care* nurse researchers.

Application: using the framework in practice

The Caring nature of the RN, depicted by the GRN in the reflections, was as important as the enactments themselves, thus the inclusion of this concept was fundamental to the framework. The research showed that there were RN who were innately *Care*, and that those who presumably found it difficult to Care, appeared to be non-*Care*. I posit that two levels of Caring should be defined, although in reality there will be gradations within these two levels in clinical practice. Through active listening and being professional, the RN who finds it difficult to Care or is simply work-oriented, is able to give care that is perceived to be *Care* and will be functioning on Level I. On Level II the RN who is 'Caring-from-within' delivers nursing care on a different level. Using the same enactments/strategies of *Care*, this Caring RN takes on a professional level of *Care* and the patient knows there is *Care*. In maintaining the *Care* on a professional level the RN is less likely to stress/burn out in the current climate of health care. The two levels are conceptualised as being:

LEVEL I On the first level the RN approaches the patient professionally with Unconditional Positive Regard (UPR) and through active listening the *Care* is Individualised. At this level the patient perceives the care to be *Care*.

LEVEL II On the second level the RN again approaches the patient professionally with UPR but there is a synergy of innate Caring and wisdom in which the patient's needs are discerned and in the receiving of Personalised care the patient knows *Care*

The basic premise of having two levels is that the RN (or student) who is 'caring from within', and who for the most time operates on Level II, will be able to move from the second level to the first when personal factors arise and they are not able to fully operationalise their *Care* with discernment. Conversely, there is also the possibility that in nursing speciality areas such as palliative care, the RN (or student) who normally operates on Level I will be able over time to move to Level II.

The Expert Panel – collaborating for depth and diversity

The second evolving episode was the meeting with the Experts. It was a process that would give "richness and validity" to the research process as the dialogue involved sharing the lived experiences of teaching undergraduate students of experts (Bray et al., 2000, p.5). This process of dialogue, followed by searching the literature and reflection, is a continuation of the cyclical evolving process of participatory/collaborative research. Meeting with the experts created a depth and breadth to the research process as well as being part of the "devil's advocacy process"…facilitated by the "cycles of divergence" (Bray et al., 2000, pp. 59,109). Importantly, this concept of divergence and convergence is also part of a validation process (Heron, 1996; Heron & Reason, 1997). It is also a process that Bray et al in an evocative description calls "phenomenology-in-several-voices" (Bray et al., 2000, p. 109).

The expert panel, one lecturer (a second lecturer was, at the last moment, unable to attend) from education, one from nursing education and a clinician, met in a faculty board-room of the university. Brief notes were taken by a research assistant, and the supervisor of this research was also present. The expert panel has also been discussed in Chapter 4.

The dialogue began with a brief presentation of the background to the research and a summary of the findings that gave form and substance to the framework. The tone of the dialogue was one of collegiality and constructive critique. The panel recognised their important role in this research and had taken their responsibility seriously. The information that had been sent had been carefully perused and questions formulated.

The discussion centred around clarification of the issues and comments on the PPCar* framework. The discussion is best summarised by rephrasing and combining some of the pertinent questions that were used for the next cycle of this research.

- The setting of objectives is important – how does this tie in with teaching *Care*?
- How does this relate to the setting of value objectives?
- How can a framework like this be included in a curriculum?
- Is there profit to be gained from returning to the education literature?

- What theories of education can contribute to the concept of teaching values?
- What theories of nursing are relevant to the research?
- What has already been done in the nursing research regarding the teaching of *Care*?
- Salovey and Mayer's work on Emotional Intelligence is seminal. Further consideration of their work may be profitable.
- Have you included an ethic of care in your exploration of the subject?

Some of the questions had been dealt with in the research and further analysis and incorporation into the thesis had been considered unnecessary. There were two considerations as to why it was unnecessary. The first was a generic/practical one in that the length of the thesis could well become problematic as more detail was included in the discussions, and secondly there were specific areas that had already been researched, and had not been included in the framework. An example is the final question above on the ethic of care. It is an important area. There are those who question the language of care, and who contend that it is no more than rhetoric and thus *Care* can never be ethical (Cortis & Kendrick, 2003). The moral foundation of nursing that is rooted in relationships (read *Care*), Kelly (1998) suggests, is simply embedded in the "ordinary everyday moral actions nurses engage in by responding to another human being in distress" and that these may be relatively simple such as making a patient comfortable or "listening carefully" (p. 1135).

The work of Salovey and Mayer (Salovey & Meyer, 1998) and the concept of emotional intelligence had also been briefly investigated as indicated in Chapter 2. The flexibility of the PPCar* framework to allow lecturers to decide what content to put into their teaching would allow for strategies such as the use of inexpensive books that aid in the development of emotional intelligence, such as Wood and Tolley's compact book on *How to assess and boost your EQ* (Wood & Tolley, 2003). It was decided not to explore emotional intelligence any further.

The context of the framework is education and the panel suggested an excursion into some of the literature on curriculum, objectives and the teaching of values. It was because of this advice from the expert panel that the detour into some of the education literature was made. The excursion into the literature is selective, as the intent was to develop a breadth to the literature that had already been explored.

This is in keeping with the cyclical nature of Bray et al's Collaborative Inquiry (Bray et al., 2000) and Heron and Reason's notion of divergence and convergence (Heron & Reason, 1997).

My experience of the expert panel mirrored the comment "Rigorous reflection, especially when done in a process of social interaction with others, can be both exhilarating and painful" (Bray et al., 2000, p. 11). I found the process was exhilarating in that the research was confirmed and the framework praised for its cohesiveness in incorporating a number of important concepts. It was also painful in that there were suggestions for further direction. Even at this stage I was becoming aware of the shortcomings of the framework and looked forward to an evolving of and final formulation of the *Care* framework. As a result of this dialogue, an investigation into issues of curriculum design and generation of objectives relating to the teaching of values ensued. This brought a new focus to the problems associated with teaching values.

The intended focus of the conceptual framework remained firmly in my mind. The ultimate goal was to incorporate the results of the research into a teachable, practically oriented framework that would facilitate *Care* practice in the future RN. In the development of the framework, I posited that it must fulfil the following criteria:

- The facilitation of *Care* must be easy to understand and transferable to the clinical area. (The theory-practice gap must be bridgeable.)
- The framework should be broad enough in scope to allow for adaptation by the lecturer so that the framework becomes the lecturer's own and in so doing fulfils a fundamental premise that the teaching of *Care* is role modeled.

Teaching it as a 'must do' denigrates 'Caring in nursing' to a prescriptive notion. There is an implicit message in some (or is it all) of the literature on 'Caring in nursing' that every nurse must Care for every patient. An example is the notion that Caring and Nursing are synonymous. The PP*Care* teaching framework proposes that it is essential to give care that is professionally proficient and is perceived to be *Care* by every (or most) patients. Gastmans (1998), in his discourse on values in a changing environment, notes that Caring will always be affected by the context, thus furthering the notion that *Care* cannot be prescribed. He notes that the nurse is in a

unique position, functioning as a professional as well as being human. The variety of contexts will also always affect the Caring, directly or indirectly, as well as limiting or stimulating the caring that is shown to patients (Gastmans, 1998). The humanness of the nurse is seldom addressed in the literature, although it is apparent in Watson's latest book *Caring Science* (Watson, 2005).

Exploring the Education literature

A decision was made to limit the reading in education to texts in order to gain a broader understanding of the literature on curriculum and the setting of objectives. It was decided that the journals where research had a narrower focus would be too narrow. Unlike the literature review where in philosophy, religion and psychology, the selection focused on individuals, the particular fundamental educational concepts were briefly explored using texts. The exploration into the teaching of *Care* had been done but was not included in the literature review. The return to the area was beneficial and is included here with the incursion into pertinent education literature and its application in nursing education.

Curriculum

> Curriculum is the pulse of the school, the currency through which teachers exchange thought and ideas with students and the community. It is the passion that binds the organisation together. When we address curriculum, we address the very heart of the educational exercise (Costa, 1999, p. x).

Although Costa is addressing the curriculum document as a whole, I posit that the 'heart' is reflected primarily in the mission statement/philosophy at the beginning of every curriculum document.

In nursing, the philosophy enunciated in curricula generally includes notions about *Care* and the commitment of the faculty to generating *Care* in the undergraduate students. Unless missions/goals or aspirations are made clear the university/faculty/department will not achieve anything or get anywhere. Indeed the nursing regulatory authorities have a manual regarding the formal requirement in curricula. The mission statement is included as being an important part of the curriculum requirements and the accreditation submission.

On a more prosaic level, Toohey (1999) proposes that although the key questions in the development of curricula are firstly, what the student should know, and secondly the methods of how the students will learn the material, he notes that the second question is not always addressed. Toohey then answers his own second question in a discussion on the difficulties that universities face in the pressures to be efficient at less cost. He maintains that the pragmatics of economics over-rule the excellent research about higher learning on how to generate the qualities of being able to think critically through research and analysis (Toohey, 1999, p. 20). In a discussion on nursing curricula, Bevis (1989b) notes that there are four curricula, the legitimate, illegitimate, hidden and null. The legitimate being the accredited curricula and importantly, the hidden which is for the most part 'contextual' and is often 'powerful' (Bevis, 1989b). Although Bevis is writing about nursing curricula, association with other university departments would indicate that this is applicable across disciplines.

Ramsden (1995) notes in his discussion on curricula in general that courses that focus on content are less effective than those that aim for student learning. If this is indeed the case, there is an urgent need for the curricula and assessment of learning in Australian universities to be addressed. The introduction into universities of computer systems that focus on course/unit specifications and grades (by inference this includes curricula) is such that the student learner has almost disappeared. Learning is content driven. Perhaps this is why there is the need to introduce graduate attributes. The students are expected to leave with attributes such as the ability to think critically and to be able to write effectively. The outcome of a university education is thus not only the discipline and professional requirements but also the attainment of what is known in general terms as the 'graduate attributes'. These attributes sometimes mirror the professional qualities and in many cases the detail is repetitious, resulting in curricula documents containing large amounts of hot air. While this sounds facetious, it is not. The end result is what Bevis (1989b) calls the problem of having more than one curriculum within a single curriculum. The enormity of the problem is encapsulated in Toohey's comment that, "Differences in beliefs about the purposes of education and the consequent *design of courses may not be resolvable*" (Toohey, 1999, p. 69) (emphasis mine).

Toohey (1999) identifies five philosophical approaches to curricula or course design (discipline-based, performance-based, cognitive, experiential and socially

critical) and comments that although they can be clearly defined theoretically, they seldom exist as single notions in practice. Although it is self evident that nursing curricula are discipline-based, it must be noted that nursing curricula have a history of a distinctive performance-based philosophical approach to curricula. This dominance of 'performance' can still be seen in some curricula, and is the direct result of the historical influence on the development of nursing curricula. Bevis (1989a) recounts the development of curricula and nursing education in the USA, noting that with the transfer of some nursing programs to community colleges and universities, curricular became more structured. Following the work of Ralph Tyler at the University of Washington, School of Nursing, the Tyler model was adopted across the USA, influencing nursing curricula in Australia as well.

Bevis continues this analysis in noting that this model was behaviourist and the insistence on reaching the objectives in order to gain nurse registration became an end in itself. The importance of quality safe care enshrined in reaching the curricula objectives became a "liability and a danger" in achieving scholarly, competent, *Care* nurses in a complex health care environment (Bevis, 1989a, p. 30). Nursing in the USA adopted and adapted the Tyler model so entirely that the curricula became "laws so immutable as to make the Ten Commandments easier to break without bringing down organised condemnation" from registering authorities (Bevis, 1989a, p.31). It was/is little different in Australia. It is however noteworthy that in the discussion on curricula, Bevis notes that the behaviourist model curriculum is contrary to the health care system of the time, and even more so today. The suggestion is made that "only by being educated as scholar-clinicians can nurses be professional" and then be able to deliver "compassionate, skilled nursing care" (Bevis, 1989a, pp. 17-18).

The 'heart' of curricula is also of interest to accrediting bodies (in its broadest sense the community) and the nursing councils in Australia are prescriptive in what is required in the curriculum. Usually a detailed document, the curriculum contains the philosophy and mission statements of the university and of the department conducting the course, the availability of resources, and the details of the courses/units and clinical practica. The curricula documents are weighty – figuratively and practically. The required detail has been inflated phenomenally over the last 20 years. The word 'inflated' was used deliberately for two reasons. The first is that, with increasing litigation in society, the professional body is as careful as

it can be to ensure that student nurses receive as comprehensive an education as possible in order to practice safely. The second factor is that universities also have an accreditation process and, in order to satisfy the funding bodies (the government) and the quality processes, there is an increasing amount of detail. The focus is on content. Ramsden makes the significant comment that if a professional body has minimum standards for practice they should be separately specified (Ramsden, 1995).

REFLECTION

The nursing registration bodies still require a reaccreditation process every five years in undergraduate nursing courses. In addition, the quality and computer requirements of the university that I work at have become increasingly prescriptive. I asked myself some questions about curricula.

Is the legacy of behaviourism still reflected in many of the nursing curricula? What impact has the student load on real learning? Almost all of the nursing lecturers are still from the hospital system – how real is their understanding of graduate attributes? These are all questions that are not within the ambit of this research. Yet the education of nurses to *Care* is. It is small comfort that the authorities on education believe that the issues, such as course design, are ones of contentious debate and '*may not be resolvable* (Toohey, 1999). If curricula do not meet required standards, the registering authority may well bring organised condemnation on the heads/co-coordinators of undergraduate nursing programs. It is not a pleasurable prospect.

Objectives

For the last 50 years, aims, objectives, goals, topics, key ideas and even instructional and performance objectives are terms that seem to have been used in a liberal way, depending on the particular theoretical perspective from which the educational writer came. The interest in objectives has continued, evidenced by the extensions to Bloom's taxonomy by the Australian, Dawson (1998). Mager's (1975) text on the writing of instructional objectives, first published in 1962, was a 'must have' for nursing lecturers in the late 1970's when nursing moved into the tertiary sector in Australia. This probably reflected the fact that nursing was initially transferred to colleges of higher education, where instructional objectives were the

norm, and the influence of the Tylerian approach of the USA nursing courses (referred to above) had not diminished. A further factor was that in the past the syllabus/curriculum was centralised, controlled by the state nursing registration boards. The setting of objectives was seen to be of paramount importance.

While Bloom's taxonomy is well known, what are less well known or even perhaps forgotten is the work of Krathwohl, Bloom and Masia (1964) and their work on affective objectives. Significantly, even Krathwohl et al (1964) note that the distinction between the three domains in education is artificial and although some objectives will fall easily into one of the groups there are often components of a specific objective that will fit into the other two classes. Thirty years later Krathwohl notes that it is still a "persistent concern" that there are three divisions as the three domains "overlap". He concludes that this will need to be considered by those who "attempt" to revise the Taxonomy (Krathwohl, 1994, p. 197). The use of the word attempt is interesting, as if with the wisdom of experience and hindsight, the development of the taxonomy has not solved the problems of setting educational goals.

There is, however, debate as to the value of objectives, such as the fact that in higher education the setting of these objectives trivialises the content, and that analysis, synthesis and creativity are not measurable. Further, it is argued that in being too prescriptive, multiple objectives will, at times, prevent lecturers taking opportunities to be creative in their teaching (Bevis, 1989; Toohey, 1999). On the other hand, Ramsden considers the setting of objectives from the students' perspective. Objectives are seen by students to relate directly to assessment and, combined with an inherent need/drive by some students to get a good grade point average, fall into the trap of collecting the right information (implicitly as lists to know) simply to pass the assessments. He notes that this reliance on objectives is too narrow a view and counter productiv (Ramsden, 1995). Thus it seems that the teaching/learning equation is not right and the educational experience becomes "focused (on) what the students need instead of what teachers have to offer" (Toohey, 1999, p. 133).

I wondered if this indeed was the old 'catch 22' situation where a fine line has to be drawn between the objectives of a course and allowing deep learning to occur in students, that will create the pursuit of lifelong learning in the student. Perhaps it would be well to remember "that there are different ways of devising

course content (that) will suit different subjects, different students and different lecturers" (Ramsden, 1995, p. 136). While the ideal is for a tailoring of objectives and course/student/lecturer/content, reality dictates otherwise. The freedom to be able to do this is often hampered by professional and university accreditation requirement. While it is central to maintain standards and congruency in curricula and units/courses, the freedom to be creative as well as staying current is further impeded by the requirement to notify changes of more than ten percent to both the above authorities. Personal experience has shown that incremental changes of ten percent a year sometimes make a course very different over a period of time. It is just as well that accreditation, from a quality perspective, takes place on a regular basis.

Toohey (1999) echoes the problems of separating objectives in the three domains referred to by Krathwohl et al (1964) some thirty years ago (above) suggesting a much broader approach. Toohey (1999) notes that objectives (and goals) should be clear enough to allow course accrediting bodies to clearly identify content as professionally justifiable, while also allowing students to see why they are doing a course/unit and what they need to know to be successful. A number of characteristics for educationally sound objectives are discussed. The important ones for this discussion are summarised as follows.

- The objectives should reflect reality and the end result should be clear so the student is able to see how the knowledge will be utilised.
- The objectives must be clearly placed within the context of the subject matter of the particular course/unit.
- The objectives should include a clear description of the behaviour that is required and how it is related to the course/unit. (A comment is made that in this area the behaviourists were correct in that judgements can only be made in the *contexts* of the student's performance.)
- Depending on the nature of the objective, it should allow for either mastery or progress. There should be evidence that students are in the process of reaching the objective/s.
- The total number of objectives should be restricted. In this way both student and lecturer remember the objectives and structuring teaching and learning

> becomes easier. This will allow "time in the curriculum for the students to undertake the kinds of exploratory and expressive activities which deepen understanding and creativity" (Toohey, 1999, pp. 150-151).

Gagne, Briggs, and Wager (Gagne, 1992) however, suggest that attitudinal objectives should be set within the context of the total curriculum through the use of instructional curriculum maps that relate cognitive theory, motor skills and attitude formation to each other and that sequential learning is planned so that the cognitive, motor and attitude domains are built on (and into) each other. This is most likely in keeping with Toohey's (1999) notion that the total number of objectives should be restricted.

Gagne et al (1992) also deals with the problem area of the assessment of attitudes/values, an area that nursing has not solved. (I was reassured to read that this had not been solved in education.) The assessment, if it is self-reporting, may well be biased, as the student tries to impress the examiner and if an independent observer does the assessment, it is rarely objective. However "Since the strength of attitudes is what one wishes to assess, it is evident that mastery cannot be identified" (Gagne et al., 1992, p. 269).

Gagne's statement above forced me to stop and think. This research on *Care* identified *Care* and non-*Care* RN. In essence this is <u>incorrect</u> if it is only the strength of an attitude that can be assessed. In other words, attitudinally an RN *cannot* be either *Care* or non-*Care*. I returned to some of the research and found there was no reference to the fact that it was only strength along a continuum that could be measured. Then the question arose in my mind as to how one might place anyone along a *Care* continuum. As an example the clinical assessment tools invariably ask (in one form or the other) whether a student is *Care* and never if they are not *Care*. The subjectivity of such assessments must always be taken into account. That is unless the patient/s send a clear message to the facilitator that the student is Caring. If this is the case, the question has to be asked as to whether the student is Caring all the time to all the patients or whether a particular patient relates well to a particular student. In addition it could be successfully argued that if a student is non-Caring, there is no need to comment on the fact as the assessment is only seeking the Caring behaviours. There is no reference to non-Caring behaviours.

Or as Gagne points out, “mastery cannot be identified” and by extension, there can be no mastery in *Care* (Gagne et al., 1992).

The setting of affective objectives is problematic, and the teaching of values difficult, neither concept can be divorced from the even more problematical area of the assessment of these values. Toohey (1999) focuses briefly on the notion of using practitioners in assessing student performance in the workplace. The point is made that this is a difficult area as the practitioner takes on a dual role, that of teacher/mentor and assessor. There is a suggestion that the lecturer should be a co-marker (Toohey, 1999, p. 184). It is an interesting concept - in a university department with an undergraduate enrolment of over 600 students, this is something that could not be undertaken. The concept bears mentioning in the discussion of role modelling as it is an important factor in ‘teaching’ *Care*. The word clinical facilitator is a good one and adequately describes the role of the RN who is facilitating clinical learning in the student in the health care setting.

Finally, a warning from the past, written some forty years ago, written in the opening chapter, Krathwohl et al (1964) mention that they had noticed over a period of years an ‘erosion’ of the affective objectives in various courses.. Although it was a statement about what had transpired **in their past** it should also serve as a prophetic warning as affective objectives, mainly about Caring and *Care*, have become ‘weary’ in nursing curricula and significantly eroded in clinical assessment tools. It seemed as if it could be a case of history repeating itself. Indeed, affective behaviours are difficult to assess as seen in the clinical evaluation tools that colleagues and I have devised and revised over the years. I contemplated the fact that in the early years of the transfer to higher education, the notion of *Care* was important. I wondered if a similar ‘erosion’ of *Care* had taken place.

The recent emphasis on graduate attributes, and the need to include them in curricula, is important as some of the attributes are value based. There has been an assumption in the past that graduates will develop these attributes within the context of the disciplinary knowledge at university. This inclusion of attributes in curricula compounds the problems of what and how students should learn. Scoufis (2000), writing for Australian universities, cites eight graduate attributes. Three of them are value driven and are related to multiculturalism, ethical issues and group skills/understanding (Scoufis, 2000). Toohey, a British author, on the other hand, cites 17 generic graduate attributes. Five are clearly value based such as “to act with

integrity" and "to treat others humanely" (Toohey, 1999, p. 72). These last two are fundamentally important to the co-existence of humanity, yet are so fundamental that one would expect all university entrants to have these significant and vital values. The question of how these values can be taught is immediately raised. Scoufis (2000) does make some suggestions, citing, among other concepts, 'encouraging deep learning', 'professionally relevant assessment tasks', 'scaffolding the development of an attribute', 'encouraging students to scrutinize/inspect their own learning' and 'the importance of good teaching practices'. In other words, the focus should be on the student learning and the academic facilitating, issues central to the curriculum (Scoufis, 2000, p. 6).

Teaching values

While the importance and debate on instructional objectives continues, the significance (and teaching) of affective objectives does not receive much attention. There was no problem in locating theories on how the traditional "reading, riting and rithmetic" should/could be taught and learned. Children can learn to read by word recognition, spelling out syllables or even 'phonetically' and mathematical skills can be taught in a variety of different ways. Moreover the outcomes are measurable, and teaching and assessing pose few problems. Armstrong and Warlick (2004) challenge the notion that the 3R need to be expanded into the 4E to deal with the computerised information environment. Of interest here is the fourth E, 'Ethics: Right and Wrong on the Information Highway' or the ability to use computerised information ethically (Armstrong & Warlick, 2004).

There is consensus about the fact that it is difficult to teach values (and by extension, ethics) and the literature uses a plethora of synonyms for values. Attitudes, moral education and affective knowledge are all used sometimes interchangeably in the same text or article. There is a strong argument that values cannot be taught and that they are assimilated over the years as the child grows in maturity through adolescence to adulthood (Faust, 1969; Peters, 1970; Raths, Harmin, & Simon, 1966; Taylor, 1999). In spite of this, the literature provides some suggestions as to how these values or attitudes can be taught and/or learned.

There is an assumption/expectation that in primary education (and possibly secondary) teachers will teach values to the student. (I wondered about the role of parents.) This is in contrast to nursing where, historically, the nurse is presumed to be

vocationally inspired, and therefore there is no need to teach *Care*. While the emphasis in nursing is on service (and caring attitudes are assumed to be already present) the emphasis in teaching is on formation (the pupil is taught to be caring). St Augustine, some eighteen centuries ago, dealt with the notion of education and emphasised the importance of the relationship between the pupil and the teacher. It was, he wrote, fundamental that the relationship between the pupil and teacher be amor, that is, a loving relationship (Augustine, 1969). This teacher-pupil relationship that he describes, one may argue, is one that is entirely possible when the size of the class is in single digit numbers. The relationship was one that was ongoing, a group of students lived with St Augustine, and there was obviously a trusting, loving relationship built up over a period of time. The transference of attitudes, skills and knowledge from the master teacher occurred in the culture of amor and encouragement. I decided that it was probably not out of date but certainly unattainable.

Gagne et al. (1992) defines attitudes as being "complex human states that affect behaviour toward people, things, and events", and that this can be further expanded by the notion that although an attitude is an internal state affecting a person's choice of action toward another, it cannot be measured (Gagne et al., 1992, p. 86). Because of the complexities of values, the teaching of attitudes is also complex and there is still much to discover about how attitudes are learned. Gagne et al. (1992) gives a brief overview on the teaching and learning of attitudes asserting that it is not by "persuasive communication" and that a more sophisticated theory of how attitudes are learned must be sought. He posits that attitudes are learned in two ways, directly and indirectly, the most important being indirectly. The indirect method is primarily through a process of internalising the values, attitudes and behaviour of someone who is known and admired by the learner, a role model, the parent and the home being the primary source of learning (Gagne et al., 1992). However, some guidelines are given for teaching/learning of attitudes. Eleven strategies are discussed and there is no mention that these strategies are given in any specific order.

The first and second guidelines that Gagne et al propose are related to choices and the implications that follow when a particular choice is made. It was, I presumed, a reward and punishment strategy. I related to this as a parent, having used this approach effectively with our own children. However I had an instant

reaction to the use of consequences in teaching *Care* – and argued that in nursing there is no choice. Patients need *Care*. The power of reward was apparent in three of the reflections, when chocolates were given to the GRN (and staff) in recognition of *Care* behaviour.

Gagne et al (1992) deals with the importance of role modelling in his third strategy, but states that the teaching of attitudes and values should fit into the wider framework of the environment. The importance of a role model in teaching attitudes and values is frequently mentioned in the literature and the power of the caring RN as a role model is implicit in the GRN reflections.

A qualitative study, by Collinson and Killeavy, (1999) extending across three countries clearly demonstrates that St Augustine's amor concept is still buoyant and practised by some teachers. The study examined the philosophical beliefs and dispositions of exemplary teachers (high school) in England, Ireland and the United States. The over-riding philosophy of the teachers was a 'knowing' or respect of their students which generated a Caring environment conducive to students learning Caring. The respect was found to be three dimensional in relationships between the teacher-student, student-student and student-teacher. In addition, and fundamentally, respect was found to be powerful, multidirectional and multifaceted. The value of respect in the classroom was elemental to the creation of a Caring environment and subsequent learning of values by the students (Collinson & Killeavy, 1999).

A second study of note was the report on a state-funded scheme in Michigan, USA to facilitate professional development with a focus on Caring (Jenlick & Kinnucan-Welsch, 1999). Teachers spent two weeks of the summer holidays in a camp, followed by regular meetings during the school year. The aim of these initiatives was to foster the notion of constructivist learning of values as well as Math/Science content through a Caring environment. Teachers could then generate, in their respective schools, the same Caring concepts. The result of the initiatives was such that the groups continued to meet after the initial period. The teachers had realised the power of community and the effect that it had in turn on their professional lives (Jenlick & Kinnucan-Welsch, 1999). The community of St Augustine is reflected in this study as well as the one above.

REFLECTION

A colleague's husband is housemaster at a large private boarding school, and dropping in for a late afternoon visit to their home (attached to the boarding house) is always interesting. A pervasive calmness prevails, amidst the obvious activities next door, and the fact that each boy is amor-ed as part of a big family indicates why the couple are so valued and respected. It is a modern day interpretation of St Augustine's teaching and learning and one that is probably rare. I related this to the love and support among each other that many nurses reminisce about during their time in the nurses' homes of yesteryear. Even the formidable Home Sister 'Cared' about her charges. The reflection of the ex-RN turned horticulturist, in Chapter 2 echoes this.

I reflected that the processes of curriculum design, objectives and the teaching of values as discussed in theoretical education were challenging. There was no single prescription in any of these three areas. Indeed, a prescription is not what I had been searching for. I had been looking for a breadth of understanding and the journey had been an illuminating one. The amor-ing of the boys in a boarding school and the nurses' homes of the past could not be translated into a university. Surprisingly it appeared that there was a theory practice gap in education (as well as in nursing) with theoretical aspects given more weight and student teachers and the problems in their practicum being largely unnoticed (Ramsden, 1995). It is an interesting parallel.

Role modelling, a caring culture of learning, integrated learning, scaffolding learning and self discovery were common themes in the educational literature on the learning of values/attitudes. In the Twenty-first Century, large impersonal classes and reduced time in the classroom – a semester is only 13 weeks – mean the task of teaching values is difficult. The references were not old, and I reflected on the theory/practice divide again. The teaching/learning of attitudes (values or affective traits) received limited attention in the educational literature. There appeared to be no theories, only suggestions/recommendations, on how to teach attitudes.

The learning of negative values appears to be easy, as many parents will attest to, while teaching and the more central aspect of the learning of positive values needs consistent hard work.

Exploring the Nurse education literature

In keeping with the reflective aspects of CI the discussion on nursing education contains two reflections from the researcher. The first is brief, reflecting on the evolving of the processes in this phase, Phase II. The second reflection is longer - my interpretations of teaching in undergraduate programs. There is a discussion on some of the research into the teaching of *Care*.

REFLECTION

> The expert panel's suggestion that there could be a further exploration of the research into the teaching of *Care* was initially, for me, enigmatic. I had read the *Care* literature widely and was conversant with the literature. The recommendation from the experts was to separate out the teaching/learning of *Care* and critically look at this single aspect of *Care* again.
>
> That I had possibly glossed over the teaching and learning of *Care* is not surprising. Woodward (1997) notes that in spite of the substantial focus on *Care* in the literature, affective objectives in nursing curricula in the UK receive scant attention. In Australia the multiple objectives in undergraduate nursing programs have, in some cases, become untenable with objectives in four areas. Theory (lecture/tutorial/self-study), practice (laboratory – skills based), graduate attributes (incorporated as part of the university requirements) and the Australian Nursing Council Inc. competencies (used mainly in clinical practice) are all featured in curriculum documents. The use of computerised spreadsheets has enabled curriculum writers to cross-match the objectives in impressive tables, often difficult to read and sometimes only intelligible to the writers

The following section on the teaching/learning of *Care* does not cover all the literature but has been limited to actual research that has focussed on teaching *Care*. An aspect of the research that became apparent was that the research was rarely longitudinal, and a follow-up to check if the teaching strategies had worked, was largely absent. In addition it must be noted that the sections with separate titles are in fact artificial. Although some of the research is primarily focussed on one aspect,

such as role models, the other factors, clinical experience or innate Caring, impinge on the specific factor researched.

Teaching

The research on the 'formal' teaching of *Care* is limited, and this is understandable. This is not surprising as I suggest that the dynamics of using specific strategies to teach *Care*, and then to evaluate is problematic. There are, however, two recurring concepts that are referred to in the nursing literature regarding the facilitation (learning) of *Care* in the undergraduate nursing student. The first is always explicit and is the concept of the importance of learning through role modelling (Barr & Bush, 1998Crowley, 1995 #39; Glass & Walter, 2000; Iwasiw & Goldenberg, 1993; Kosowski, 1995; Owen, 1993; Wiles, 1975Davies, 1993 #180; Wilkes & Wallis, 1993). Most of this literature also implies the second concept, the growth of *Care* as the student works in the clinical areas.

There is little research on the teaching of *Care* in Australian universities, particularly in the bigger ones where the yearly student admission rate is greater than 200 students. The research into the development of a professional caring in nursing students in two Australian universities is therefore important. Using two open ended questions and selected interviews, Wilkes and Wallis (1988) documented the changes and growth in *Care* in students across the three years of two nursing programs. (Differences between the universities were also investigated.) It was not a longitudinal study as student from each year participated at one point of time. Over 450 students participated in the study and a random sample of 180 texts was analysed and 11 telephone interviews were conducted.

The major themes that emerged were Compassion, Communication, Concern, Competence, Commitment, Confidence, Conscience and Courage (Wilkes & Wallis, 1998). The terminology is not always meaningful, although the table heading indicted that the definitions were definitions that emerged from the study. Conscience is defined as, "Looking at the individual as deserving of respect. Taking account of their actions. Conscious that the person is as 'good' as themselves." and Commitment is defined as "Doing things they did not want to do. Expression of the activity of love. And Not showing bias". A model of "professional nurse caring" was developed from these themes (Wilkes & Wallis, 1998). From a student perspective, 'professional nurse caring' took place in a nursing context and was

directed to the 'health and well being of patients'. Their discussion on the 'enactment' of the caring attributes indicated that 'caring' was sometimes lacking because of the demands of the clinical situations. Although this can be 'painful', these occasions will 'always be a learning experience for the professional nurse' (Wilkes & Wallis, 1998, p. 588). The authors note that there are limitations in their study, as it was not longitudinal, and the development of the *Care* concepts that the students enunciated could not have been attributed to a single cause.

Reynolds, Scott and Jessiman (1991), in a comprehensive and scholarly analysis of the research on teaching empathy, indicate that there are a number of problems in the research on empathy as well as in reality, indicated by "low levels of empathy in nursing" (p. 1183). This statement is not referenced or justified, and parallels the results in this research. Reynolds, Scott and Jessiman (1991) define empathy as being what the client perceives empathy to be, and is therefore difficult to measure and to teach. In spite of the discussed difficulties in teaching empathy, the importance of having a client-generated framework of empathy is emphasised. They conclude that clinically based education may be more meaningful as a means of teaching empathy as it provides the student with feedback from the clients (Reynolds, Scott, & Jessiman, 1999). The importance of empathy is not disputed, but it is difficult to know why the single concept of empathy was chosen. Empathy, as being able to feel at one with or to have rapport with another, is as difficult to define as *Care* and Caring. Indeed The New Oxford Thesaurus of English Language gives the informal interpretation of empathy to be able to 'put oneself in the shoes of', (Hank, 2000) the same interpretation of *Care* given in the Modelling and Role-Modelling theory of nursing (Woodward, 2003). Educators in nursing interpret a concept in one way; clients interpret the concept in another way.

There is not much point teaching unless some learning results. The research into formal teaching was scant, and assessment of the learning that had taken place, general. Of greater import is the learning of Caring through group experiences; in other words there was little teaching.

Gramling and Nugent (1998) described a unit specifically dedicated to teaching *Care* using the strategies of reflection, direct teaching of Watson's carative factors and the presentation of skits by students. Formal evaluation of student learning was done by the submission of written incidents of *Care* behaviours noted by the students that they were either part of or had observed. Evaluation of these

written incidents indicated that the students had effectively learned about *Care*. Informal anecdotal evaluation of the unit was positive. There was no formal evaluation of student *Care* behaviours in the clinical setting (Gramling & Nugent, 1998). This is an example of the problems that could occur in the research on teaching *Care*. It should be noted that the evaluation was a self-evaluation, something, I suggest, that is fraught with difficulties. An evaluation indicating that a student has not learned *Care* is tantamount/indicative of inappropriate teaching or a student that has not been paying attention, or worse still, a student saying that they do not have the intelligence to understand.

A second research project investigating the formal teaching of *Care* was done in Ireland. The research evaluating the use of the arts in teaching caring across all the nursing programs offered in Northern Ireland is constructive. A high proportion (77%) of the lecturers made use of the arts when teaching in nursing programs, and although the most common medium was literature, poetry and film drama were also used. Increased interest, together with a greater understanding of *Care*, were significant results of using the arts in teaching. The lecturer respondents found that using the arts was risky, as they had not had formal training in this medium. However the use of the arts was more effective in smaller classes. Most of the participants had positive reactions from the students, although over half had not had any feedback on the long-term effects on the use of the teaching methods (Grindle & Dallat, 2001). Here again the classes were small, making the use of the arts, specifically the literature and live drama, much easier.

A few studies on the development of *Care* through experience, that is focusing is on the learning, are of interest. These studies make the assumption that students, having experienced Caring in groups, are then able to transfer the Caring learned into the enactment of clinical *Care*. It is an important concept, and especially significant when factors such as Generation X and Y and the instability of the late Twentieth Century home environment are taken into account.

In a study in the USA, a program of experiential ‘caring groups’ of 12 students, led by a faculty member, achieved the objective of students *experiencing* Caring over the two years of the nursing program. Students felt that they were able to help create and feel part of a Caring community, and moreover they themselves were changed and became more Caring in the process (Grams, Kosowski, & Wilson, 1997). The positive nature of the experiential learning in a small group was evident.

Kosowski, one of the researchers in the Grams et al study, in an earlier study on *Care*, found a secondary outcome of her research was that a special bond was created with the students in the research group (Kosowski, 1995).

On my recent trip to the UK, the university at which I spent a month's exchange had a similar small group program. There were some 12-15 students in each group and the group stayed with the same academic leader for the duration of the three-year program. I was able to spend a few hours with one of the groups. Seeing and feeling the closeness within the group was a worthwhile experience. The common factor in both the Grams and Kowowski research cited above, in the USA and the other in the UK, was the small yearly intake. In the USA the intake was 40 students and in the UK it was 100, while in most universities in Queensland the yearly intake is double the UK intake. It is self-evident that the teaching of *Care* to large numbers has inherent problems, and the feasibility of having small 'caring groups' of 12 students is obviously out of the question. A recent study into the impact of peer mentoring and the dynamics of *Care* on a single small group of nursing students at one of the smaller universities in Australia demonstrated the importance of such a group to personal and professional growth. (Glass & Walter, 2000) The significance of the study is that positive group dynamics developed quickly over a period of twelve weeks, probably a semester. The usefulness of small groups that will generate positive *Care* needs to be acknowledged. Resourceful strategies need to be created in order to bring into being such groups in universities with large enrolments.

Learning to *Care* and then *Care* clinically, specifically when there is some incompetency, raises some interesting questions. In reality, learning to *Care* may well be considered by some to be of secondary importance to the competency of the novice. The 'safety of the patient' is a phrase that is intoned with almost monotonous regularity in undergraduate nursing programs. It is the single most important phrase used in clinical laboratories. Bradshaw in a set of two articles, (1997, 1998) argues convincingly that the competence of the RN is of the utmost importance and then notes that the tertiary system does not always ensure competency in practical skills. The question as to who should be teaching the clinical skills is raised, as the new graduate confidence levels are low when they are struggling with everyday skills as well as the professional image of being a registered nurse (Bradshaw, 1997, 1998). Bjork echoes this in her research and maintains that

there is little in the way of research into the attainment of practical skills in nursing. The complexity of the skills when practiced in reality is not recognised (Bjork, 1997, 1999; Bjork & Kirkevold, 2000).

The ability to show *Care* when a RN is not comfortable clinically is not mentioned by either Bjork or Bradshaw. I posit that it is difficult or almost impossible for a novice RN to show *Care* when they are ill at ease and thinking of 'what to do next' instead of focussing on the patient.

Clinical experience and role modelling *Care*

It is difficult to analyse exactly whether it is the 'where' and thus personal experience or the 'who' that generates the learning of *Care*. Research has to delineate the two during formal research and therefore a larger study into the combined power of these 'learning' forces should be undertaken. Two GRN reflections indicated that they had learned *Care* through negative role modelling of RN while they had been students. Patton's conclusion in relation to the above notion is noteworthy.

A study into the senior nursing students' perceptions of the *Care* behaviours of their preceptors was undertaken in Akron, USA. The importance of the support the preceptor gave, as well as the impact of role modelling, were significant. Patton and Woods conclude by noting that further research is needed to find teaching strategies that will enable nursing students to learn *Care*, and whether "caring is communicated implicitly as well as explicitly" (Patton & Woods, 1995, p. 367).

Greenhalgh, Vanhaned, and Kyngas (1998) in a study on self-reported *Care* behaviours of nurses in psychiatric and general hospitals, found that anticipatory *Care* increased with experience. Anticipatory *Care* is defined as those behaviours that anticipated changes in a patient's condition and tailored interventions to the anticipated needs. Anticipated *Care* is a sub-scale in the Care-Q questionnaire used to measure *Care* quantitatively. The suggestion was that nurse educators should 'increase the stress on caring behaviours in the nursing curriculum' (Greenhalgh, Vanhaned, & Kyngas, 1998). While this is important, there is no suggestion on how these behaviours can be taught. Stressing a value in a course may in fact detract from other essential content. The argument can be carried further, that if it is true that some *Care* behaviours are only learned through experience, then there need not be an emphasis on these behaviours.

The importance of clinical experience and the resultant growth of *Care* in students is clear (Greenhalgh et al., 1998; Nelms, 1990; Reynolds et al., 1999). There is no reason to think that these results cannot be generalised to nursing in Australia. There are inherent difficulties in the notion that nursing students will learn to *Care* in their clinical placements. The limited time that students spend in the clinical area prior to graduation is highlighted in the national reviews of nurse education (Heath, 2002; Reid, 1994). In personal communication with a member of the Queensland committee for clinical placements, Geoff Wilson, I was told that the situation is currently of great concern. The committee has not considered the implications for the learning of professional *Care* by students; the issue of obtaining enough placements for students outweighs any notion of addressing such 'theoretical abstractions'. These are matters of serious concern.

In a significant study, Simmons and Cavanaugh (2000) investigated the development of Caring Ability (CA) in a longitudinal study of 545 nursing students over three years. In phase 1 a random sample of students (junior and senior) across the USA completed three questionnaires on their own CA, a self-rating of parental caring during their first 16 years of life, and school climate ratings. There was no relationship between the respondents' own CA and the rating of their parental caring. There was, however, a significant positive correlation between their own CA and a school climate rating, age, and importance of religion. Three years later, the same survey instrument was again completed by 189 of the students who had by then been working as RN for one to two years. There were two important results. Firstly, CA scores had increased by an average of 4.4% (greater than one half a standard deviation) between the two surveys. Secondly, the nursing school environment was the second strongest predictor of CA. In other words, there was a continuing development of CA, showing that it can be learned. The study also indicated that Caring encounters with faculty have a long-term effect on students preparing to nurse (Simmons & Cavanaugh, 2000). Thus it seems that the CA is an innate Caring ability that was translated into an ability to *Care*.

Clarke and Wheeler (1992), in a phenomenological study on *Care* in acute care nursing with six registered nurses in current practice, suggests that there is a lack of understanding about what both nursing and Caring really mean. There is a suggestion that Caring is something which cannot be touched or seen and although it is innate, needs to be experienced in order to appreciate it and practiced in order to

continue doing it (Clarke & Wheeler, 1992). This highlights the importance of positive clinical experiences for students in undergraduate courses. Limited experiences in terms of time and sometimes in quality of experience are factors of national debate and review in Australia, and need careful consideration when the teaching and learning of *Care* is discussed.

The two studies discussed above (Simmons and Clarke) are thought provoking. Although the Simmons and Cavanaugh (2000) study does not deal with the links between CA and Caring parents (there is an assumption that there is a strong connection), Clarke and Wheeler (1992) are explicit in the notion that *Care* nurses come from a Caring background. The rates of divorce, the level of domestic violence and child abuse have increased dramatically in the recent past and are alarming. In addition the trends to have an only child and the movement away from the family home with career moves and travel compounds the problems of a Caring environment and the impact this may have on (younger) students, those entering university straight from school. The impact that these factors have on the CA of students is something that I have not explored. Teaching or facilitating *Care* in these students needs to take into account the concept of the X and Y Generation discussed in the next paragraph. It is a compelling aspect to teaching not only *Care* but also the rest of the curriculum.

Heath's analysis of the current undergraduate nursing student in Australia indicates that only 37% are school leavers (Heath, 2002, p. 223). Although this is a relatively small percentage, it is high enough to have an impact on a student cohort as well as a significant impact on the dynamics of a hospital environment. The analysis does not indicate the Generation factors, something that I will only refer to briefly. Sadler's (2003) brief description of the Generation Yer's (just 21 at the time the article was written) is interesting and challenging. She notes that this generation are 'selfish' (as are the previous generation, the Xer's) and possibly enter nursing for altruistic reasons, and are also,

> …very materialistic and disrespectful. They are marked by a distinctly practical worldview and are very technologically literate. They are trying to grow up too fast without good role models. This generation has been raised in dual-income and single parent families (Sadler, 2003).

These students, as well as the mature age students, make a very different group to the students of yesteryear. I did not investigate the teaching of the Y'ers, except to note that in an Ovid search, there was limited material. Management strategies to cope with the mixture of the Generation X'ers and Y'ers were numerous, an indication that it is an area that nursing education still has to deal with.

A colleague teaching into a course on Family Health recounts that there are always students who have never held a baby. The Caring and security of either a bigger nuclear family or extended family must influence the values that are assimilated in a happy family atmosphere. I find teaching Child Abuse a challenge as there are always students I can identify as being troubled as the subject is being discussed. The Simmons and Cavanagh (2000) study indicated an experiencing of Caring in high school and its direct relation to the Caring Ability of the respondents, indicating an experiential Caring. This is akin to Clarke and Wheeler's (1992) assumption that Caring needs to be experienced prior to being able to practice it. If these two studies are correct, and there is no doubt that they are, *then* the need to have courses in which Caring is *seen* as well as *taught* is imperative.

Although some undergraduate students will come with good interpersonal skills, many will need guidance in dealing with a broader range of people with a need-level that they have not dealt with before. I reflected on the task of teaching social skills and wondered about the impact of teaching manners, particularly to the Generation Yer's. Jaeger refers to the 'manners' problem briefly calling them 'social sensibilities' (Jaeger, 2001) and I realised that the problem obviously existed. The importance of having manners is underscored in the work of Goleman who categorically asserts that social skills are an important part of promotion in the business world (Goleman, 1999). It is a sad descriptor of society in this century that it is a skill that needs to be 'taught' or learned. I wondered about the 'selfishness' of the Xer's and Yer's – the future RN. I also linked this to the important area of patient satisfaction. After all, part of the emotional competence is an ability to deal appropriately with the customer (patient) leading to customer (patient) satisfaction.

Davies (1992) conducted a grounded research study of six first year students and their discovery of new knowledge gained through observation of role models during their first clinical placements. The positive and negative perceptions of the students were explored over this period. The *Care* 'artistic' role model of nursing care (as opposed to the uncovering or finding of scientific knowledge) was the most

important finding in the student's reflective accounts as well as interviews with Davies. The personal growth of the students in *Care* is also noted (Davies, 1993). Although the sample was small, for these first year students the clear recognition of *Care* could not have been seen without an innate sense of Caring within themselves.

Nelm's (1990) phenomenological study focussed on the lived experience of the students and the assertion that "Students told me unanimously that the single most meaningful aspect of their lived experiences was their clinical experience" (p. 290) and that "in most cases the value of any learning experience was directly related to the personality of those who teach them and the one-to-one interaction with that person" (p. 296). The lived experience of the student is important and although the research deals with the role-model and the experience separately the two cannot be divorced. This sums up exactly my experience over the years with students. The meaningfulness of the lived clinical experience is often apparent. Many return from the first clinical experience 'glowing' from their first encounter with real patients.

Bevis issues a challenge to nurse educators in her discussion on the "moral ideal of caring" in nursing. Nursing is difficult but also offers the chance to participate in "some of the most sublime activities that one person ever has the opportunity to do for another". If, she notes, educators are going to 'entrust' society to our students then, "It becomes the moral responsibility of nursing educators to study theories of caring, read the literature on caring. And *practice caring, making it as natural to their lives as breathing"* (Italics mine) (Bevis, 1989c, p. 183).

Was it a reality that lecturers could practice caring as suggested by Bevis? The actuality of juggling large numbers of students, keeping in touch with clinical developments and personal research is challenging for lecturers in Australia.

The importance of role models, clinical experience and innate Caring ability is unquestioned. How these impact on each other is difficult to determine, but is worthy of a larger study on the relationships of these factors to each other and the impact on the student and ultimately the patient.

The following is a longer reflection of some of the aspects of teaching nursing and a questioning of a few of the concepts that I consider problematic.

Teaching *Care* – my reflection

In keeping with the important aspect of reflection in the methodology, I paused and considered some aspects of undergraduate teaching in nursing programs.

I returned to the third cluster of the analysis of the reflections and it seemed there was a common theme of the importance of the patient. I singled out clinical teaching and my text books in relation to my own experiences in teaching. **There are a number of themes I reflected on, and these are in bold at the beginning of the paragraph. The paragraph ends with the last sentence in italics.**

Patients and call bells I know that communication is always emphasised. What was the teaching reality? I had already reflected on the aspect of teaching procedures and the possible impact of the frequent injunction to 'close the windows, screen the bed, and tell the patient what you are going to do' with reference to the problem of listening and communication. I had also noted that it is a problem in the older texts. I turned to a recent text, 'Elkin' (Elkin, Perry, & Potter, 1996) popular in Australia prior to 2001, when the Australasian version of the fundamentals text became available (Crisp & Taylor, 2001). The key features of 'Elkin' are described in the Preface under a number of dot points. Near the top of the list is a dot point labelled 'UNIQUE.' and the importance of the 'Standard Protocol' is emphasised, there is a chapter devoted to the Standard Protocol and it is repeated on the inside cover page of the text as a Quick Reference guide for all nursing procedures. The doctors' orders and the patients' identity are checked prior to the nurse introducing themselves and telling the patient what they are going to do.

The attention to the call bell is part of a directive to the student that it is important to respond to the patient in times of need. It is also part of the closing off of any procedure, a signal that the nurse has finished the care for that particular time. Implicitly it is also a signal that the nurse is available if the patient needs something. Significantly the patient probably interprets the message, as 'I will always answer your call, *promptly*.' Perhaps this is why the response to a call for help was a natural inclusion in the quantitative instruments measuring *Care*. Gardner et al's Australian study into patients' and nurses' perception of caring behaviour (Gardner et al., 2001) used Larson's Care Q instrument (ranking of 50 statements) (Larsson, Widmark, Lampic, Von-Essen, & Sjoden, 1998) that includes the statement 'gives a quick response to the patient's call'. The patients ranked the response to a call fourth while nurses ranked the behaviour as twenty-fourth. This is extraordinary considering the emphasis that is always placed on the call-bell and even more extraordinary as nurses placed listening to the patient as the primary *Care* behaviour. The protocol for

completing the procedure is to make the patient comfortable and to 'Be certain client has a way to call for help and knows how to use it.' *Although the emphasis is on safe care and the patient is central there is an undercurrent of depersonalisation of the patient.*

Abstract patients and nursing diagnosis I turned to reflect on the patients' place in teaching. Locsin argues that the nursing process and the use of nursing diagnosis not only perpetuates the medical model but also is detrimental to *Care*. A diagnosis in medical terms is justified as it has a scientific pathological basis whereas the nursing diagnosis is an attempt to predict something that is unpredictable as the uniqueness of the patient "renders the nursing diagnosis inadequate, fractional, and inappropriate" (Locsin, 1997, p. 361). The nursing diagnosis formula has been a central concept in nursing texts for many years and yet it is not used clinically in Australia. The theory practice gap is thus perpetuated. This was further justification in my thinking that lecturers (sometimes without having given the notion any thought) do depersonalise the patient.

Further confirmation of the notion of the depersonalisation of the patient, despite the lip service to the contrary, is highlighted in Suzanne Jaeger's (2001) work on teaching ethics. Jaeger explores the intricacies of teaching students to reason critically and independently when confronted by moral dilemmas. The importance of the nurse to be able to be in tune with the patients and to sense the moral framework that the patient is operating from is fundamental to good ethical practice. The point is made that it is 'immoral' to treat patients as if they are 'abstract' individuals with the only right they have is that of 'autonomy'. Indeed, Jaeger concludes that the inclusion of abstract theories in the teaching of ethics is emphasised to the point of excluding other concepts such as the patients' own individuality including their moral thinking and reasoning (Jaeger, 2001). It is an interesting comment on the way that nurses are taught when over the years the references to the patients' autonomy have been frequent. Autonomy is an ethical concept that has possibly worn thin around the edges as lecturers intone the importance of the patients being able to decide for themselves. *Professional experience and conversations with carers in the nursing home sector tell that elderly residents are still being bathed every day and certainly not at the time of their choosing.*

Patients' autonomy and advocacy I also teach ethics and the concept of advocacy and autonomy are closely related. It is worthwhile to note the progression on advocacy in the successive editions of *Bioethics – a Nursing Perspective* by the Australian ethicist, Megan-Jane Johnson. The second edition has a chapter devoted to the importance of being a patient advocate, which concludes with issues and recommendations indicating that "helpful strategies aimed at better protecting patients' interests and well being should be pursued more rigorously" (Johnstone, 1994, p. 287). The passive image of the patient is clear. The advocacy chapter is excluded in the third edition and the word, advocate, is not included in the index (Johnstone, 1999). In the fourth edition the concept is included in the index in connection with the family and the patient's Advance Directives (Johnstone, 2004). The patient is being considered an equal partner in their health care, something that is not always evident in reality. Johnson has noted this and changed her texts accordingly. I reflected on the implications of the advocacy issue as interpreted in Johnstone's (1994) second edition of her text. I questioned how many lecturers were still teaching the advocacy of 1994. *It is an approach to nursing that over the years has depersonalised the patient.*

Patients and nursing theories Was there further evidence? The knowing that it was there was simply not good enough; it had to be substantiated. Theories of nursing were the focus of the search for nursing knowledge beginning in the 1960's with the establishment of the Nursing Theories group (Marriner-Tomey, 1989). It is a significant period in nursing scholarship and has of late fallen from favour. What must be borne in mind is the fact that the nursing theories were an essential part of the educational programs of some two decades ago. While they are no longer formally taught, there are thousands of practicing RN who were indoctrinated into these theories at that time. I have also taught theories. Years ago. It was here in the metaparadigm of 'person' that I started to find what I knew was possibly a fundamental problem in some of the nursing theories. In addressing the 'person' the patient had in essence become depersonalised. An example is Abdellah's Typology of 21 Nursing Problems, "developed to constitute the unique body of knowledge that is nursing" (Dycus, Schmeiser, Taggart, & Yancey, 1989, p. 94). The first of these problems is to maintain good hygiene, and one is left to cynically wonder if it is the ward or the patient needing attention. The critique in the chapter devoted to

Abdellah notes that the generality of the model is wide and does not have patient centred outcomes (Dycus et al., 1989). Dorothea Orem, the theorist I often used, is a further example. I quote in part from four of the eight propositions of Orem's theory.

- Nurses determine the current and changing values of patients' self-care requisites, select valid and reliable processes or technologies for meeting these requisites and formulate the courses of actions necessary for using selected processes or technologies that will meet identified self-care requisites….
- Nurses determine the current and changing values of patients' abilities…
- Nurses estimate the potential of patients…
- Nurses and patients act together…in the development of patients' self-care capabilities.

It is the final dot point that indicates for the first time that the patient is in a position to know personally what is going to suit them although it is possible that the patient is in a subordinate position as the statement includes the words "in the regulation of the patients …" (Orem, 1985, pp.72-73).

Patients need to be patients … I was part of the problem of the depersonalisation of the patient. I too had erred on the self-care concept. On the other hand, sometimes patients do not want autonomy, advocacy or even momentary self-care. They are too ill, or scared, to make decisions. It is a concept that requires discernment (discussed in Chapter 7), the ability to walk along a fine line of patient autonomy and taking over the care of and *Care* in the process. Wilson (2004) takes the view that autonomy should be reconsidered as she notes that autonomy has become an 'overriding principle in health and palliative care ethics'. Although from a palliative care focus, this concept is poignantly summed up by Jeff, one of her patients.

> When people are children they depend on their parents and when they grow up they begin to depend on themselves. Most people are probably the same but not me. I want to depend on someone, but nobody will let me. For the past six months or so I have been wishing I had someone to act as a mother to

> me. Someone I could confide anything to, someone who'd take decisions out of my hands, someone who would care for me (Wilson, 2004, p. 13)

I was as guilty as some of my colleagues. I had not even considered it. *I had not taught discernment in allowing patients to curl up and be nursed.*

Me? a role model? … I considered that the significance of the Role model concept in the learning of *Care* is often overlooked, and I reflected on the importance of the lecturer in the university. The nursing lecturers in undergraduate programs are no less important role models than the practitioners in the clinical settings. Nevertheless teaching into a course/unit with 200+ enrolments, the lecturer will often not see a particular tutorial/laboratory group for more than two hours a week. Names are not easy to remember when there are eight groups (30 students in each group) that the lecturer is taking. How can the lecturer role model genuine interest in a student whose name they cannot even remember? I am sometimes embarrassed when a student drops in to ask me something and I do not even remember that I taught them the previous semester. Caring? Of course I am, but I wonder what the students' perceptions are. It is a problem…compounded at times when lecturers are accused of being 'not caring' when they fail a student or when they are not always present in their offices just exactly when the student comes to see them. Students will sometimes report to the course co-ordinator that the lecturer in question is 'never in her office'. I know they are in their offices in the stated student 'consult' times. The nexus between being Caring, being professional, maintaining standards and helpfulness is difficult.

The problems associated with large numbers of students in Australian programs are further compounded by impersonal lectures to large groups of students. Recently the lectures at this university have been recorded onto the computer network and students are able to listen to lectures at home, as well as being able to view the PowerPoint presentations. The students have found the system invaluable as they can now listen at a time that suits them. Difficult concepts such as ones in pharmacokinetics can be listened to more than once. There is much to commend the system. Conversely the impact of such lectures on aspects of *Care* and not being able to have the personal contact with the lecturer has not been evaluated.

In summary, the comment from Bevis (1989d), considered an authority on nurse education and *Care* in the USA for many years, is still timely.

> Education is an elusive concept. A clear definition is impossible, for no clarity emerges from the literature. Therefore, rather than a definition there will be a discussion of characteristics and narrative depictions, which do not define education so much as describe it contextually.
>
> …these highest forms of human achievement must be dealt with in a context of real problems and issues that engage the educatee in ways that affect the modes of approaching not only the fields of study involved but also normal life problems (Bevis, 1989d, 155).

It reflects the complexities of nurse education, a need for a theoretical foundation as well as the importance of the clinical environment as students learn to come to terms with a profession that should always centre on the patient.

Conclusion

The expert panel had led me to a deeper understanding of the importance of role modeling, curricula development and objectives. As I reflected I came to the realization that the timing of the formulation of the PP*Care* had also influenced the creation of the framework. It was the end of the academic year – when courses were being updated, reflecting the organisation of the university's courses.

Further reading had also influenced my deliberations. There were two important concepts that needed to be taken into consideration. The first was a theoretical issue that would need to be resolved on a nursing department/faculty level and the second was the practical issues related to the climate of *Care*.

- The theory of *Care* - curricula

Care is articulated in the philosophy of nursing departments but is difficult to formulate as objectives. Hence 'universal' mission statements of *Care* have been incorporated into nursing undergraduate curricula, often motherhood statements. The lack of specificity sometimes leads to a focus on tangible nursing concepts that are easier to teach. In addition, teaching values are acknowledged as being complex.

- The practice of *Care* - Clinical growth in *Care*

The importance of role modelling cannot be overstated. There are difficulties in the universities and the clinical milieu. In large universities with a considerable student enrolment in the nursing department, contact time with the lecturers is minimal and the impact of the role model is negligible. There are differences in the way universities plan the clinical practicum and these also impact on students learning *Care*.

Research indicates the importance of clinical experience and the growth of *Care* as students participate in their practical. The current technological climate has depersonalised the patient and the current reduced length of patient stay means there is little time to form even the most fleeting of relationships. Yet the increased level of acuity in the patients suggests there is a greater need for *Care* care.

New generation students (future RN) who are not necessarily vocationally inspired have to be initiated into the complexities of relationships and *Care*. It is an issue that needs to be addressed if the importance of nursing as Caring is to remain.

There was a need to dovetail these issues in order to formulate a strategy that would fit the complexities of the education of future RN. It was at this point that I realised that the conceptual framework of enacted *Care* that I had developed was based in a theoretical world. In spite of students growing in their *Care* abilities in their planned clinical experiences, they also needed supportive prior learning of Caring. There was a need to move beyond the theoretical bases of *Care* to a practical reality. Phase III would allow for reflection-on-reflection and explanatory reflection and these are addressed in the next chapter.

Chapter 7: Phase III – Reflection-on-reflection

The evolving episodes in Phase III, the final phase of this research, uses reflection-on-reflection (Bray, Lee, Smith, & Yorks, 2000) and explanatory reflection (Heron, 1996) as Phase I and Phase II are revisited. Bray et al (2000) also call it "a higher level of reflexivity" (p. 76) as well as "making meaning" (p. 14). It is a process where a deeper level of questioning occurs, and I wondered with excitement, as I formally entered the final phase, what I would uncover. I was challenged by the injunction that,

> …collaborative inquiry builds on creativity and even playfulness in methods not being slavishly wedded to a particular methodological approach. What is important is the development of strong norms around pursuing a variety of methods and raising challenges to the validity of *emergent meaning* (Bray et al., 2000, p. 109). (Emphasis mine)

The words "emergent meaning" struck me with force. The analysis and interpretation of the GRN reflections in Phase I had been included in the teaching framework developed early in Phase II. However the excursion into the education literature, suggested by the expert group, together with a reflexive refocussing on the teaching of *Care* were important episodes that led into Phase III. There were two aspects that had started to surface. The first was that the teaching framework was too prescriptive and the second was the significance of active interest in the patient. The method of evolving concepts, and the tenet of emerging meaning, is in keeping with the underlying philosophy and methodology of this research. Although Phases I and II are pale in the model of the cyclical process on the following page, both phases retain their importance. The evolving episodes in Phase III culminated in a decision to take the framework and create a practical model of *Care*.

Figure 7.1 A three phase cyclical process

Phase I – How is caring enacted? – the GRN reflections

Participants	*Evolving Episodes*
The GRN group	Reflections on caring enactments
Researcher	Analysis and interpretation of reflections
Six GRN meet	Dialogue on enactment analysis

Phase II – A framework for teaching? – the experts

Participants	*Evolving Episodes*
Researcher	Integration of related literature and the interpretations from the reflections resulting in the PPCar* framework
The expert group	Discussion of proposed framework – PPCar*
Researcher	A return to education literature

Phase III – Reflection-on-reflection – the researcher

Participant	*Evolving Episodes*
Researcher	Reflection-on-reflection on Phase I and Phase II
Researcher	Re-constructing meanings

Introduction

I paused. Meaning making is not a linear process, it is leap-frogging in an orderly fashion – ensuring that concepts are revisited and reflected on. New and re-reading throws fresh light on key concepts. Phase III would involve episodes of reflection-on-reflection and explanatory reflection. This would necessitate a stepping back and a reviewing of the concepts and reflections that I had already written in light of the two research questions. The first question asked about the practicalities of the skills of *Care* and the second question asked for a framework in which *Care* could be taught.

Reflection-on-reflection and an emergent meaning

Reflection-on-reflection, or a higher level of reflexivity, is part of the processes in Collaborative Inquiry where a deeper level of questioning occurs and is part of the reflective processes necessary to examine the construction of meaning (Bray et al., 2000, p. 76). Although Bray et al (2000) consider it part of the group processes, at this stage I was alone, and it remained a critical part of Phase III.

Heron (1996) describes the process differently, and identifies "explanatory reflection as being a higher order of thought" and that there is transfer of learning from one reflection phase to another. He suggests a number of methods to cultivate and develop explanatory reflection. Two of these aids/methods that he describes were used for this process of explanatory reflecting in Phase III. They were "loose construing" and "convergent thinking". Heron advocates using "loose construing" in the early stages of explanatory reflection as it is a fluid process in which there is a "making sense of past experience with a light and loosely fitting set of concepts that lets the experience breathe" (Heron, 1996, p. 144). The second method that is suggested is a process of convergent thinking, defined as "Reflecting on divergent aspects and perspectives, refining each and bringing out the common ground they illuminate." Heron recommends that this should take place in the later stages of explanatory reflection (Heron, 1996, pp. 143-144).

The first question, dealt with in Phase I, asked how *Care* is enacted? There were six key *Care* enactments that had come out of the GRN reflections on enacted *Care*. These were Extra mile, Listening, Active Interest, being Respectful of families, Touch and an ability to put patients at their Ease. The two key *Care* acts of

listening and touch were already described in much of the research and literature on *Care*, and although the other four were important, I reflected that there was a quintessence in the reflections that still needed to be identified. The second question, explored in Phase II, involved the development of a teaching framework; however the spirit of the second question asked how these enactments could be taught. Research into teaching *Care* indicated that there was a growth of *Care* ability in clinical placements and the impact of the role-model on learning *Care* was a powerful one. Thus teaching *Care* needed to be done bearing these in mind; a holistic concept that melds the theoretical as well as the practical.

Phase III assumed a fresh reality as the incidents of Phase I took on additional meaning and the reading advocated by the expert panel in Phase II gave new meaning to the research and I started to wonder about the possible reconfiguration of the teaching framework.

While the reflexivity of the researcher had to this point been a part of the overall process, I had not reflected-on-reflections of the research as a whole. I turned to the processes of loose construing and convergent thinking. This I did by returning to each chapter. It is the salient aspects of this reflection-on-reflection and explanatory reflection that are recorded here.

Reflections – Chapter 1

I returned briefly to the definitions of 'care', and found among the meanings that had been discarded, the concept of 'serious attention'. It is the third definition cited in The Australian Oxford Dictionary and is worthy of comment. (Moore, 1999) Superficially it is not connected to *Care* and yet fundamentally it is part of the care component of nursing that is taught in all clinical laboratories and foundational to the safety of the patient. It is in essence at the heart of the 'five rights of giving medication' to check, to check, to check… 'serious attention' is fundamental to all care that any patient receives. The balance of safe care using complex Twenty-first Century technology requiring intense concentration could be seen to counter against the patient being seen as a real person. Carefulness, awareness, due care and vigilance are other synonyms but it is the 'serious attention' that is fundamental to safe practice in a climate where litigation is common. As I reflected, I wondered if it

could be possible that a patient could sue a nurse because the second most important *Care* enactment, listens, had not been invoked.

I felt as if I had come full circle, back to defining, something that I did not want to do. As I reflected I reasoned that the research and discussions on *Care* had left out this important component in the thesaurus like interpretations of Caring/*Care*. *Care* should always be done with due care or 'serious attention'. The listening of the enactments, I reflected, cannot occur unless there is a preparedness to truly give 'serious attention' and 'due care' to what the patient is attempting to convey. The word 'attempt' is very deliberate as patients in a compromised state of health and in strange surroundings may not always be clear in what they are saying. It is not only the words that need to be paid attention to – real listening in nursing particularly needs a combination of all the senses to truly listen and interpret the message that is being sent. I would need to keep this definition of 'care' in my consciousness as I proceeded.

Reflections – Chapter 2

The literature review dealt with four over-arching themes in Caring and care. These were historical glimpses of patient care, the present climate of care, a review of selected philosophers and their interpretations of Caring followed by an excursion into some of the literature on *Care*. As I returned to reflectively focus and use a deeper level of questioning, I began to have some reservations about the way in which the patient had been portrayed. The focus on the dominance of disease had cast the patient in a secondary position. I found to my chagrin, the final sentence in a reflection, 'Perhaps the emphasis on the patient was one that has been missed in the configurations of the *Care* RN.' There was an emerging thought that I, too, had left the patient out of the equation. The patient was not in the previous teaching framework. What is more, I began to wonder about a concept in which nurses assume a 'matriarchal' position towards their patients. Nurses are well versed in the subordinate position that they take to doctors, as the doctors exercise authority. I considered that we had done the same to the patient. It was an interesting and challenging thought, which I did not follow through. I did however side-track into a re-consideration of the patient and asked myself if 'patient satisfaction' would have a bearing on my deliberations.

Patient satisfaction

I turned to the limited literature that I had on patient satisfaction. It **is** limited. In Semester II, 2004, a student elected to do their research topic on patient satisfaction and was dismayed to find so little had been done in the area. Procedures and policies have become paramount losing the patient and patient satisfaction in a sea of paperwork.

The paucity of research on patients' perceptions of *Care* and patient satisfaction is attributed to a reluctance to be honest and being fearful of poor treatment in future admissions (Coyle & Williams, 2000; Hyrkas & Paunomnen, 2000; Hyrkas, Paunonen, & Laippala, 2000; Reynolds, Scott, & Jessiman, 1999). Patistea and Siamanta (1999) extensively reviewed the research regarding patients' perceptions of caring and a combination of patients' and nurses' perceptions of caring. Research that focused only on nurses' perceptions of *Care* were not included, as much of the research on *Care* is nurse-focused. The meta-analysis covered a period of fifteen years, and there were only thirteen studies that dealt with patients' perceptions of *Care*. The limited research indicated that while patients essentially focus on competent care there was congruency in that "both nurses and patients expressed their desire to respect individuality in caring relationships" (Patistea & Siamanta, 1999, p. 309). Safe care is a legal requirement and I speculated again that it is not surprising that *Care* studies with patients are limited.

Ray's (1989) theory of Bureaucratic Caring (not often quoted) is a theory that is essentially practically based. The importance of the different perceptions of caring within hospital departments (allied health and administration) is highlighted. The essential element of this research and theory that needs to be emphasised here is that the patients "primarily expressed the need for human care and had to *devise strategies to get* what *they needed"* (Ray, 1989, p. 35). (Emphasis mine.) The focus was on the need for individualised care. A similar result in an Australian study was that patients felt that they had to be 'good' in order to have an effectual relationship with the nurse (Irurita, 1999).

Coyle and Williams (2000) argue that determining the clients'/patients' views of what is needed in a Caring nurse is difficult. The intricacies of undertaking research to determine the patients' views of health care, particularly when a mixed

method of research is used, are highlighted in a post-research critique of the research into patient dissatisfaction (Coyle & Williams, 2000).

I wondered about the patients 'who do not conform' to RN expectations. Were patients left out because they did not fit in with the notion of what a 'good' patient should be? I remembered that we were always taught that 'difficult' patients simply did not exist. Was there a new perception about patients? Patients are now categorised in computer systems that indicate levels of care needed. While this is a necessary management strategy, it depersonalises the patient into a 'workload statistic'.

I began to be alarmed. I knew that the *Care* research indicated that the patients' and nurses' perceptions of *Care* did not always match. Although I had noted this discrepancy, I found myself questioning it at a deeper level. Research into patients' perceptions of *Care* in two quantitative studies indicated that the patient felt that nurses had not listened (Gardner et al., 2001; Hegedus, 1999). My questioning led me to another aspect of listening. Not only was the patient not listened to, but there was also a reference to the fact that the voice of the patient has also been silenced. Digby (1997), is authoritative in his conclusions that the voice of the patient has been silenced by the technology, in that the technology has taken over the valuable history taking by the doctor and as a result patients feel "profoundly alienated" (Digby, 1997, p. 298). If this is indeed true then the importance of listening to the patient becomes central to an interpretation of *Care*. The 'his' of the 'his-story' has been supplanted by 'oscopies' and 'imagings' that are available as adjuncts to diagnosis. The technology of itself has become indispensable to early definitive diagnoses but often involves long periods in waiting rooms or cubicles, leaving the patient feeling they are just a number in the queue. Havener (1979) advocates being careful about taking histories and decries the use of a long series of questions, comments that computers will not solve the problem, and that,

> ….a history is not the comprehensive withdrawal of all facts from the patient's mind, as cider is drained from a keg.
>
> Worse, …impersonal and routine list of questions *does not permit development of the positive interpersonal attitudes that are so important in patient care*

> ...each patient is different and not even the expert is clairvoyant to know the outcome in advance (Havener, 1979, pp. 25-25) (Emphasis mine).

It is 15 years since Havener (1979) commented that computers would not solve the problem. Computers have become more complex and have even compounded the problem of developing a 'positive interpersonal attitude' with patients. Experientially I have found that to be so. Using a computer has meant that returning to a General Practitioner for a repeat prescription has further reduced consultation time. A perfunctory blood-pressure check, a click of the mouse and the prescription is delivered. The de-personalisation of the patient (me) was apparent. A RN in another city used to boast that she could take the standard hospital nursing history in five minutes. I wondered if there had been any research on history taking and the development of a 'positive interpersonal attitude'. There was. A study into the perceptions of nursing care of a group of patients from Pakistan who had immigrated to England is not a compliment to the nursing profession. The findings primarily indicated that the patients felt marginalised, and that there was a high degree of cultural stereotyping. It was also found that the assessment phase of the nursing process in which the nurse interviews the patient to elicit problems and plan care was 'mechanistic and ritualistic' (Cortis & Kendrick, 2003).

I noted only two studies into patient satisfaction done post Patistea and Siamanta's meta-analysis, Irurita (1999), and Schmidt (2003). Schmidt's study is small. A grounded theory analysis of patients' perception of nursing care was carried out to determine the factors that were crucial to patient satisfaction of their hospital experience. Schmidt identified four categories of perceptions from the patients' point of view, 'seeing the individual patient', 'explaining', 'responding' and 'watching over' (Schmidt, 2003). It is an important qualitative study, as the categories that were identified can be seen to encompass many of the previous results obtained in other quantitative research. An instance is that in the 'responding' category, patients expected timeliness in response to their call, a reflection of the 'gives a quick response to the patient's call' in the Larson Care Q instrument (Gardner et al., 2001; Hegedus, 1999; Widmark-Petersson, Von Essen, & Sjoden, 1998). The need for a ready response to a call-bell also appears in a qualitative Australian study (Irurita, 1999). Significantly all studies note that the response to a call for help is usually tardy.

Reflections – Chapters 3 and 4

Revisiting and reflecting again on Chapters 3 and 4 was useful. Although there were no new insights I decided that I had been true to the philosophy of this research. I knew that I was totally committed to participatory research, and well aware of the reciprocity that occurs in research, but was surprised at my reaction to a recent short report on 'reciprocal research', a form of participatory research. Pittaway (2004) had found that women in a refugee camp were becoming increasingly reluctant in telling their stories as researchers were getting what they wanted and then leaving the camps with the women (the researched subjects) feeling robbed of the little they had. She had introduced the notion of giving 'something in return for tales of woe' when working successfully with the women (O'Keefe, 2004). Tears welled in my eyes as I reflected that the philosophy of participatory research had been available to researchers for decades, and that the women had been disenfranchised in the name of research.

Reflections – Chapter 5

Chapter 5 was the first phase of the research, Phase I – the analysis and interpretation of the GRN reflections. I knew the reflections so well. Was there something to reflect on again? The patient is identified here again – this time as being able to identify the *Care* RN. I began by using Heron's (1996) concept of 'loose construing'. In retrospect it was if I had taken a carefully sorted pack of cards and tossed them into the air and then re-sorted them again.

An emerging concept of the significance of Active Interest

The quantitative analysis had indicated that the most important enactment was the Extra Mile, so I began with this enactment. It is a loose almost fragile concept. I was certain that the enactment had been correctly named and that the reflections clearly indicated a 'doing more' concept. I considered that what may seem to be an Extra Mile for one RN may seem to be something that is routine for another RN. It was not a strategy or skill that denoted a specific action that could be taught although it was an essence of *Care*. There was something nebulous about the concept of the Extra Mile that would be difficult to teach. I drew on past teaching experience to visualise how I would teach the concept of an Extra Mile. I imagined

the average Australian class reaction to the notion that if they wanted to be *Care*, they would need to go the 'extra mile'. There may be some that would agree but many would be incredulous, maybe even disbelieving. I reflected that the Extra Mile was a focussing on the patient. The patient was taking central stage.

It was during a time of reflection and reading that I examined the "construction of meaning" (Bray et al., 2000, p. 76) together with "convergent thinking" (Heron, 1996, p. 144). I reflected that I had been looking for something that could be *done* – a skill as it were. In spite of my philosophical interest in *Care* this probably reflected my other orientation, the clinical and the necessity to teach a 'doing'. I let go the meanings that I had attributed to the enactments and looked at them again. There was an emerging concept, a dawning – a slow, gradual lightening of the eastern sky – as the notion of Active Interest began to have significance. I asked myself if there were links between the enactments themselves and the notion of the importance of the patient. Was there a philosophical aspect that I had missed? I pondered on the enactment of Active Interest.

I returned to the data. I took a clean copy of the reflections and a highlighter pen and began a new interpretative-analysis, *focusing on the incidents*, and the *context* of the enactments/strategies/skills.

I highlighted the *incidents* that reflected an Active Interest in the patient on the part of the RN. The pages were almost no longer white. They were filled with the iridescent color of the highlighter, a meaningful pattern. Which-ever-way the 'active interest' was interpreted it was primary, and was the focal point of the reflections. It was as if the sun had risen and the enactments had become illuminated with a bright morning light.

As I became immersed in the data, again, the *Care* enactments began to lose their singular significance and the incidents became more important. The five key elements began to be significant only in as far as Active Interest was operationalised. How can a nurse go the extra mile, put a patient at their ease, listen or even be respectful of the family if they do not take an active interest? Even the touch element involved Active Interest as it is only by taking an Active Interest that the nurse can determine the appropriateness of touch. Inappropriate touch is not *Care*. I posited that in all caring enactments an Active Interest in the patient was required and when combined with the remaining caring enactments true *Care* would occur. Active

Interest was in essence the primary *Care* enactment. I had not named this enactment; it had been taken from one of the reflections,

*… a few nurses obviously took an **active interest** in their patient … GRN 15*

The essence of *Care* actions must be interpreted as a single act – Active Interest. It was only in a professional silencing of the busy-nesses of the ward that a true Active Interest could hear a heart cry of the patient. Perhaps only the heart can hear a heart cry and this is perhaps why it is so difficult to capture the essence of *Care* actions. The heart cry can only be heard through an Active Interest and tuning in and listening to the verbal intonations and catching the subtle non-verbal flickers that are often shrouded by the impedimenta of technology attached to a needy patient.

I came to the realization that there was a dichotomy here. The Active Interest in the patient is the reverse of the depersonalisation of the patient that I had reflected on at the end of Chapter 6. I also realized that the *Care* RN had in some ways become identified with the *Care* enactments. They were difficult to separate.

Returning to patient satisfaction

The concept of convergent thinking, reflecting on 'divergent' concepts and then 'refining' them was like doing mental leapfrogs mentioned in the introduction to this chapter. The concept of Active Interest illuminated the common ground of the patient. I realised that there was a need to return to the patient. The Golden Age of Caring was simply putting the patients first. For nurses there was no alternative. The ward sister made sure of that. The patient was sovereign then and I wondered about the role of the patient in the present. Wickett, McCutcheon, and Long (2003), in an analysis of the nursing shortage in Australia, maintain that the patient still expects the nurse to provide all of their care. This belief of yesteryear, when there was a gentle 7-10 day recovery after surgery, persists, instead of the reality of the beneficial effects of looking after themselves soon after surgery. (Wickett et al., 2003) Patients expect care and *Care*, when in their fragility they become introspective and assume importance. This was brought out in one of the reflections when a GRN reflected that by simply understanding and supporting and helping a patient shower on the first post-operative day, the care was considered *Care*.

The *Care* research, as indicated above, is not focused on the patient. The philosophy of *Care* and nurses themselves predominate. The obvious has been disregarded as perhaps *Care* is, like beauty, in the eye of the beholder. The evidence of *Care* is only obvious in the patients' eyes, the research into patients' perception of *Care* indicate this. Sometimes the nurse will know. It can be palpable and seen by the observer as evidenced by the reflections of the GRN in this research. Sometimes it will be seen by relatives and they will acknowledge the *Care* as being something special, acknowledged by a box of chocolates or a card to the Charge Nurse. At other times it is seen and 'heard' only by the nurse and patient and that in itself is reward.

I often ask myself @ the end of the day 'have I accomplished what I believe to be my caring role?' I cannot judge it by how many people I talked to or how many coffees I made I judge it by how many smiles I get afterwards. If a pt appears to be more relaxed & more interactive with fellow co-pts then that's a plus. GRN 23

At other times the nurse will not know at the time and only later learns that something has been special for the patient. As GRN 23 reflects…

The woman came up to me later and said 'thank-you'. People usually try to talk me through but it doesn't help. Thank-you for just holding my hand. I couldn't think for a while after that. I was stunned. I had just held her hand. GRN 23

Sometimes the RN will never know. Will knowing that they are *Care* make a difference to the way that they *Care*? It shouldn't. Knowing for the RN is a bonus – *Care* without knowing is what *Care* is all about. The centrality of the patient – taking an Active Interest – is in effect the bottom line in *Care*.

As I reflected on the incidents in the GRN reflections I also came to a new understanding of the power and multi-dimensional aspects of *Care*. The GRN had identified incidents of *Care* as the RN (and often themselves) had been participants in the essence of nursing – meeting human needs at the point of the patients' need. Only as the needs were truly met did the care become Caring. The physical (the RN doing) had moved to a sacred plane without the RN recognising the fact. In a moment of time a need had been met. I wondered again if that is what Watson meant by the use of the word 'sacred' as she reiterated the concept of the caring moment in her latest book *Caring Science as Sacred Science* (Watson, 2005). It was something

occurring in a moment of time, which could not be explained. However transitory a moment, it would be remembered as *Care*. The focus is really on the patient and not on the RN. Philosophically, *Care* is intangible…although there were moments that had been captured and described by many of the GRN reflections. Although it was the actions, not the essence of what was done, that was being searched for; an Active Interest could be interpreted and transposed into tutorials, lectures and in the clinical laboratories.

I reflected on the incident of a patient with what appeared to be intractable pain. (Quoted in full in Chapter 5). Not only was it an excellent illustration of the 'active interest' concept, it also illustrated the multi-dimensional aspects of *Care*. The GRN and the other RN were also actively interested in the outcome and so took on an extra workload for the caring RN who was enacting the *Care*. These RN were not directly involved in the *Care* scenario. The bath, massage with oils, and music meant the *Care* RN going the extra mile, but then, so did the GRN and the other RN go the extra mile. The result was that the patient was put at ease and went to sleep. The ripple effect continued as the GRN and the other RN felt relief that a patient in 'their' care too, had finally found relief. I venture to say that this had an effect on the other patients as well. The patient in pain, slept, possibly unaware of the *Care*, and the absent family would never know. Was this simply good care? Yes of course it was. But, the GRN identified it as *Care*, as there was an added dimension that the GRN felt and saw. The impact of the incident was such that it was reflected on and recorded. There was also a dawning that in this case *Care* could be taught. The importance of the patient must be an ongoing theme in whatever is being taught at whatever level - the patient comes first. Linking the enactments into one had brought a new dimension to the patient. The real patient is often lost in the clinical milieu of technology and cost and the dominance of the nurse.

Peter Baume, distinguished author, academic, politician and Professor of Community Medicine at the University of New South Wales, in a book subtitled *An Ideology of Care,* is not entirely complimentary about his own profession,

> Thanks to medical science this has been the century of scientific advances in medicine when we use different belief systems and do things routinely that were unthought of and impossible 100 years ago (Baume, 1998, p. 203).

He then continues that this has led to the philosophy that the primary purpose of medicine, is sadly, the management of disease. The person, the suffering patient, is excluded.

> What the medical model does less well is help people with illnesses that cannot be cured, and what it does least well is deal with people whose symptoms and distress do not conform to the textbook (Baume, 1998, p. 205).

I reflected on Baume's views and the objectification of the patient and his indictment on the medical profession. Nursing is influenced by the encompassing climate of the medical model. I wondered if this was the case with the un-*Care* RN of the reflections. Even if it was unconsciously there! Exactly what did Baume mean by the fact that patients are not dealt with 'well'. I reflected on the egocentricity of the present. The patient expects *Care*. Nursing nearly got it right some fifty years ago when the first text in Australia was printed. Consideration, politeness, and putting the patient first were fundamental to the care that was taught (Doherty, Sirl, & Ring, 1954). My reflections on teaching and the patient indicate that the patient is sometimes sidelined.

Two millennia ago the Christian message was to 'do unto others', but the present seems to be infused with a 'me' mentality – and many nurses (and doctors) are self-centred. The emerging theme was becoming clearer. The dawning would bring a modern interpretation to the historically established interpretation of *Care*.

Nurse/patient relationships

The words roll off my tongue as I lecture – the nurse/patient relationship. The reverse – the patient/nurse relationship is seldom used. I wondered why. The word 'relationship' denotes equality and by inference the patient and nurse are in an equal partnership. Reality is that it is otherwise. I reconsidered the passage in Chapter 2 on aegis. There is a pervasive evocation in the literature that the nurse is active, in the doing and being of *Care* and cares, and that the patient remains passive. An example is the therapeutic relationship described by Travelbee (Travelbee, 1977) as one in which the nurse facilitates a relationship to enable healing (therapeutic) to take place. The unevenness of this relationship is the antithesis of Caring and *Care*. This cannot

remain. I turned to the concept of service and its relationship to the concept of professions.

(It must be remembered that there **is** a commercial side to nursing that has nothing to do with the altruistic vocational *Care* aspect. There are two sides to the patients' concept of service. They pay for the care they get, as well as often having an expectation that the care should be Caring. It is a complex issue and will not be entered into here.)

It was a discussion on the future of nursing that triggered off these connections. Is it because of the historical roots of service that nurses cringe at being part of what today is called a service industry? Summers notes, in a discussion on the future of nursing that,

> The academic model of nursing may be thwarted for many negative and ignoble reasons but in the home or the hospice the personal-service model wholly compatible with a high level of nursing education, is likely to be the one most sorely needed (Summers, 1997, p. 205).

I wondered about *Care* and what the writer had meant by 'personal-service model'. Was 'personal-service' a professional approach in which the patient is first and the service an altruistic notion? Summers, in the context of the above quotation, also notes that nurses who are "able to relate to every aspect of a patient's experience, are irreplaceable" (Summers, 1997, p. 205). If this notion is applied, Watson's model of intentionality and transpersonal nursing could conceivably be called a personal-service model, but would never be labelled such. The notion of the patient as customer had taken on a new perspective.

The personal-service concept was an interesting one, particularly when business and management principles are taken into consideration. The complexities of *Care* are multiple when viewed from an administrative aspect. There are implications for professional satisfaction as well as the marketing of the organisation (Ray, 1989; Valentine, 1988).

Kelly's (2004) sub-titles in a discussion on recent developments in critical care nursing are interesting. The importance of holistic care is stressed in the section called *The Patient is King.* She concludes that "True quality can only be measured

by the level of patient and public satisfaction" (Kelly, 2004, p.34). Was the importance of the patient and patient satisfaction an emerging theme?

I turned my attention to the RN. The RN were not part of the study as I was only looking at the enactments of *Care* - something that the RN actually did. There were two groups of RN that were clearly identified, the *Care* RN and the non-*Care* RN. The *Care* RN was a fact, as the RN of the reflections were at times indistinguishable from the *Care* actions. It is obvious that innate Caring characteristics are part of the inborn qualities that came with the *Care* RN and will continue to come with some (*not all*) of those entering nursing as a career.

I decided to refine some of the divergent aspects of the RN and, in the thinking processes, construct the meaning of the enactments that I was seeking. Alternatively would some of the convergent thinking 'illuminate' some of the ideas and 'judgments' that had already been made on the findings?

It is only five years since Parker (1999) discussed the question as to whether the patient is customer or patient. She suggests that there is little time in a commercial approach for the important personal relationships that involve "dimensions of comforting and caring" (Parker, 1999, p. 21). I agree. However. What is the reality? Health care is becoming increasingly commercial.

I reflected again on the uncaring RN. I get my petrol from the produce/hardware/petrol bowsers on my way home. So – what? I go there even when their petrol price is higher than other petrol service stations. Why? Even when there is the occasional queue the attendants (note the plural) are always *pleasant, respectful, interested and responsive.* I give them my custom because they care for their clients. I pay for my petrol and indeed most times fill the tank myself. A twice-weekly ritual and some days I am tired and fussed trying to get home quickly. I always return to the same service station as they not only meet my need for petrol and 25kg bags of dog food, but they 'care' about me. (Or appear to.) If I and all the other customers stopped going to that particular outlet they would simply go out of business. (A neighbor has just changed her ophthalmologist as he is not *pleasant, respectful, interested and responsive* or as she emphatically says that 'he does not Care.')

The altruistic view, Bradshaw (1999) calls it a covenant of care, links the historical aspect of a vocation and the dedication of Nightingale with subsequent nurses trained under the Nightingale philosophy (Bradshaw, 1999). While there is

strong disagreement with this view as evidenced by Allmark (and others referred to in his writing) (Allmark, 1998), Bradshaw makes an important point that patients are patients simply because they have a need to be nursed. She argues that nursing is not an "intellectual activity to be discussed and analysed" that it is, "at its heart, a practical activity, lived out daily in real situations with people needing help". While the practical is stressed, the importance of *Care* and problems of the "fragmentation of the tradition" and the need to return to core values is highlighted and that a "realisation has dawned that there needs now to be a reformation" (Bradshaw, 1999, p. 4).

I posit that a covenant of care does not sit easily with the student of the Twenty-first Century. While RN from two or three decades ago will resonate with this designation, others will not. *Care* is naming the concept simply, and does not have either an old-fashioned ring or a noetic association, both of which could 'turn the modern student off'.

Examining the virtuousness of a covenant of care and a purely commercial approach, it is obvious that neither sits well with a philosophy of nursing-as-Caring. I believe that Pattison (2001) is correct in saying that caring cannot be "required". He argues forcefully that the ethical codes of nursing are not ethical and, while this is an interesting professional debate, it is what he has to say about the virtuous (caring) nurse that needs to be highlighted. He takes pains to point out that it is "desirable" and even "admirable" to have nurses who are virtuous but that "it is doubtful that true virtue can be commanded or required of people in a modern occupational group even if it is applauded when it is evident" (Pattison, 2001, p. 13).

Patients still expect *Care*. I envisage Bradshaw's (1999) covenant of care as simply *Care* professionally. Thus nurses must have a strategy to indicate that patients 'matter'. The personal nature of nursing will always remain and while nurses are in a position of power over their pajama-ed patients there will always be a need for nurses who at least appear to be *Care*.

The 'art form' – en-*act*-ing *Care*

The reflections had a final contribution to make. I had reflected from time to time on MacDonald's (1993) thoughts in, *The Caring Imperative: a must?* It is worthwhile quoting from his conclusion.

> Several theorists ignore the fact that caring is done by humans who are subject to the range of human feelings and failings. Implicit in many concepts of carings are the notions that, to succeed as carers, nurses must comply with prescriptive theories of caring and forfeit their rights to the thoughts and feelings that make them the individuals they are (Macdonald, 1993, p. 30).

I returned to it, and used the process of convergent thinking, and then I returned to the reflections. There was a concept that had come from GRN 39 who had sent in the longest reflections. Part of this was due to the fact that this GRN had reflected on the nuances of *Care* as the incidents had been written and the following caught my attention,

From observance of others I have seen acting to be beneficial. GRN 39

I linked MacDonald's concept of appearing *Care* and the GRN 39 reflections. The first reflection contained material included in the Active Interest enactment, but it was the introductory short sentence that signaled something else, a deeper meaning that continued into the second reflection.

Caring is an art form. Though even if you have some insight to this skill first impressions, bad experiences, lack of knowledge etc, can reduce your ability at rapport considerably. My main point of my waffling is that caring must be titrated to each person because the only way that people see you as caring and feel cared for is if you see them as a person and not a patient. Here are some enactments to reinforce these notions. GRN 39

The 'art form' was obviously the germination of an idea that was simmering away. The second reflection seemed to be touching on the same idea as it was still there. There was *a need to tailor the Care** to different people. It was taking the 'active interest' a step further.

Some people are "touch people" or service people (doing actions shows care) rather than spending time or touch. Care needs are varied. GRN 39

Almost at the end of the second reflection the idea is openly broached. GRN 39 thinks it may even be 'taboo'. Except for MacDonald (1993), it was an angle that I had not come across.

Another part of caring that may be taboo to speak of is acting. Acting is an important part of care for Pt's, for providing the following: constant emotion (the nurse), different behavioural approaches to pt's, conveying confidence, happiness, strength, awareness and acting (using these) provides an over all reassurance. I believe this is important as nurses to talk about as we all do it, we do not always feel like caring, feel tolerant, feel awake or even compassionate at times. From observance of others I have seen acting to be beneficial as showing cracks in care can lose rapport, make the pt worry about the nurse, and generally make the pt feel uncared for. GRN 39

The primacy of the patient was once again coming to the fore but there was an element here in which GRN 39 seemed to be saying that 'I do not always feel like Caring so I sometimes have to pretend that I am Caring'. Even more importantly this GRN has observed other RN 'acting'. In research on how emergency room nurses *Care*, the category of "helping patients find their own level of comfort" had the "greatest variety of touching and talking, *tailored according* to the patient's need" (Morse, 1992, para. 24) (Emphasis mine). I asked myself if it was necessary that *Care* had to always come from the heart. I decided that it did not have to. However there always needed to be Professional *Care*.

I recalled an article – the 'chameleon one' – that I had read and not linked to anything in this research. Aranda and Sweet (1999) explored relationships in a domiciliary environment where nurses were able to get to know their patients. A new perspective to the concept of being able to personalise care is vividly and clearly explicated by likening the nurse to being a chameleon – changing their approach to suit the patient. Although communication and listening clearly involves authenticity, nurses changed and adapted to the individual patients. The caring intent of the nurse was manifest in an ability to adapt to the patients in meeting their needs, in other words, being a chameleon (Aranda & Street, 1999). 'Being real' is part of the Australian culture…images of pretence are considered as being 'not on'. In spite of this, the concept of being a chameleon is of importance. Not that a RN should or even could be 'all things to all people' – that is not possible. Being a chameleon was an essential part of personalising nursing care in the Aranda and Sweet (1999) study. GRN 39 was struggling with this concept but in terms of personalising *Care* was on target. In another part of the second reflection there is comment that

In watching other nurses I have realized we can not all provide the same type of care as we also care differently which co-insides (sic) with our different nursing styles. GRN 39.

John Macdonald (1993) is honest and more direct than GRN 39 or Aranda and Sweet (1999) and, in his exploration of the same concept, he asserts that he can care and be seen as caring while, in his innermost being, not be caring, but the patient's needs have been met (Macdonald, 1993). Is there an anomaly here? I argue not. The patients did not know whether Macdonald was caring or not and I venture to posit that the patients perceived his care to be *Care*. In a social situation or with a friend, such nuances could be picked up and the other could well remark that 'you are not being real with me.' The situation in nursing is different. It is a professional relationship and furthermore, the patient, who is for much of the time ill or vulnerable, will not pick up on the nuances and will probably never know that the RN did not Care. The whole notion of *Care* as discussed here is that it is specific to nursing.

I later use the meanings in the reflections from GRN 39 in the *Care* model – naming it *Care* Connections. The importance of the fit of the individual RN to the time and place of the encounter with the patient is fundamental to *Care* practice. There is, in addition, the important factor of the nurse adjusting to the patient as indicated in the research of Aranda and Sweet (1999) and Morse et al. (1992). Much has been said and written on the vocation of nursing, and while there are no longer interviews to assess the suitability of applicants for nursing (and I support this), there is much to be said about the selection of RN to areas of practice to which they are most suited. (There is also a presumption that there will be self-selection, but currently RN do not always get into areas of their choosing.)

Intuition + listening = discernment

Intuition and listening were RN attributes, and listening was also an enactment, therefore the context of these attributes and enactment needed to be revisited. This was part of the evolving episodes of reflection-on-reflection and a resulting exploration process. Intuition was an attribute in the GRN reflections, occurring sufficiently to be included in the attributes, but could not be included in the teaching framework as it was not an enactment. Listening was possibly more important than Active Interest as it occurred in two categories of analysis. In order

to be valid there was a need to give prominence to listening as well as Active Interest. How could the two concepts be linked? I reflected on the links between intuition, listening and Active Interest. The word 'discern' had been used only once when GRN 32 had reflected briefly on a *Care* incident as the RN discerned the need of a family and patient to be left alone.

I reflected on the meanings of discernment. Discernment had, for me, spiritual connotations, so I returned to a reconsideration of the concept. It was a word I had been taught as a child, revolving around discerning good from evil. Then a colleague entered the discussions and produced one of her many treasured books, Websters New International Dictionary published in 1934 (Harris, 1934). The first definition was the one that I had been brought up with but it had been taken out of the spiritual realm. Discern simply meant being able to 'have the power of facility of the mind by which it distinguishes one thing from another.' It is not, Webster goes on to note, imagination or moral instruction. It is 'immediate apprehension or cognition' and when 'looking on – seeing either with the physical eye or the eye of the mind'. The modern interpretation is as clear but briefer 'perceive clearly with the mind or the senses' and secondly 'make out by thought or by gazing, listening, etc' (Moore, 1999). There is little to add to this Australian definition; it was exactly what needed to be taught.

I reflected that I would only make one change – the word 'or' is used in both definitions, separating the physical and cognitive dimensions of discerning. In the nursing context it should be 'and' as the professional nurse uses the mind as well as the eye and indeed the touch as well. I considered that it would be an easier concept to teach than simple observation. Discernment, I was sure, would mean more to students. Intuition cannot be taught and I wondered if there was an aspect of discernment that could be taught and incorporated into a new model of *Care*.

I returned to the final reflection on teaching *Care* where I had reflected on the pervasive sense of the depersonalisation of the patient. This reflection-on-reflection highlighted again the possible invasive subliminal depersonalisation of the patient. It underscored the importance of the patient.

Reflections – Chapter 6

I returned to Phase III and the meeting with the experts and how subsequent reading into some of the education literature had been fruitful. This, together with the explanatory reflections and reflection-on-reflection in Chapter 5, forced me to look again at the structuring of the teaching framework. The return to the teaching framework was to have important consequences for this research. It was at this stage during a period of reflection that I understood the importance of this research and that a model of *Care* should replace the teaching framework.

Heron's (1996) divergent aspects and perspectives and convergent thinking drew attention to the fact that there was a curriculum focus on the teaching framework. This blurred some of the concepts that had emerged in this chapter. An evolving of concepts was a part of this research method, a consequential unfolding of the concept of *Care*. I had extrapolated from the research that *Care* and its enactments was a unique form of Caring. The reflection-on-reflection had added a depth of understanding to the concepts that needed to be reflected in a new model.

Care I reflected is something different, special, a way of describing a unique form of Caring that belongs to nursing. Caring is, as numbers of researchers put it, another word for nursing, therefore why not simply call it nursing. I believe it is more than that; it is a form of Caring that only nursing knows and therefore needs to be identified. *Care* does that. *Care* is not synonymous with nursing – it is an important part of nursing. (I considered that if caring and nursing are synonymous, as suggested by some writers, then there would not be non-caring.)

The teaching framework in Figure 6:1 was the final item that needed to come into a reflective focus. I came to the conclusion that the focal point was so primarily focused on teaching that the framework resembled a course guide. I had wanted the student to change and had not centered the attention on the patient and the professional behaviour of the RN. In essence the constructs remained similar – as they always would in many discussions on Caring.

Construct I – Professional *Care* would remain unchanged. These were the professional aspects of nursing that had first been refined and explored in Chapter 2 and incorporated into the teaching framework (supporting philosophies of Scott-Peck and Campbell) and remained valid. They were important concepts that would be incorporated into a new model of *Care*.

Construct II – Personalising care would have a stronger focus. Previously it was a theoretical concept that, although it included the *Care* enactments, did not make the patient the centre of attention. It was the emergence of Active Interest that had forced me to reflect on this aspect. The new model would be practically based and have the patient in the spotlight.

Construct III – Transpersonal *Care* would change significantly. Previously it was in essence a theoretical aspect of *Care* that emphasised the importance of the nurse/patient relationship. An epiphany experience occurred and I realised that the word 'relationship' should not be used in a model of practical *Care*. The ability of the student/RN to form *Care* relationships is, in most instances, no longer possible and the importance of connections would now be emphasised. The importance of the clinical milieu (place) and the length of stay (time) would influence the connection made between the patient and the RN. *Care* is not wholly dependent on the *Care* attribute of the RN.

In Chapter 1 I defined *Care* as being Caring in nursing and said it was compassion and intimately linked with the nuances of tender loving care. This differentiated it from other forms of 'caring' that were being discussed in this thesis. *Care* now needed to be modified.

The modified definition of *Care* is that it is professional, patient focused using Active Interest and should not be dependent on the Caring attributes of the RN.

I had come to the end of the reflections-on-reflection. It had been an important process in reaching the conclusion that the original teaching framework did not reflect the emergent meanings of Phase III. The framework was not sufficient and a model of *Care* needed to be created.

I considered briefly the over-riding philosophy of this research as explicated in Chapter 3 and returned briefly to Heron's (1996) overview of participative research/co-operative inquiry. In a section devoted to special skills that a researcher needs to employ, he notes among other skills, the ability to "reframe". It was a landmark in my research as it empowered me to "revision" the teaching framework. Heron says reframing,

> …is to do with the conceptual revisioning in perceiving a world. With this skill, we not only hold in abeyance the constructs being imposed on our perceiving, we also try out alternative ones for their creative capacity to

> articulate an account of people and a world. We are open to reframing the assumptions of any conceptual context or perspective (Heron, 1996, p. 59).

It was the final emergence of a journey that brought new meaning to *Care*.

Chapter 8: Conclusion and Recommendations

This participative research revolved around two questions. The first one sought to find tangible enactments that are used to indicate *Care*, and the second question, as a consequence of the first, sought to formulate a framework in which to teach these enactments. Phase I had established six key *Care* enactments used by *Care* RN to show *Care*. Phase II began with the formulation of a teaching framework, followed by a meeting with experts in education and an excursion into the literature on education. The researcher was alone in Phase III, using reflection-on-reflection. It was a time of richness in deliberation and purposefulness as I retraced my journey of the previous phases. The importance of the patient, and Active Interest in the patient, became the centre of my re-conceptualisation of *Care*. In the spirit of the philosophy of this research there was a revisioning of the concepts and I conclude with the creation of *Care*-Connections – a new model that can be used for teaching, management, and further research.

I posit that *Care* should be taught as a behaviour that is expected from all RN. *Care* is a fusion of professional Caring and Active Interest. The professional Caring (*Care*) begins with Active Interest, irrespective of the Caring qualities of the RN. As the RN takes an Active Interest, the needs of the patient are discerned and Professional cares (physical, emotional and spiritual) are given as a response and *Care* is either perceived or known as Caring.

The synergy of *Care* enactments means a single act of *Care* can never be defined. The patient is central. An interpretation of whether the care is *Care*/Caring or not, is not within the RN's province to decide. It is the patients' prerogative. (Competency is always a given.)

The *Care* Connections model was created to visually indicate these concepts. In the following sections the philosophy and the elements of *Care* Connections will be briefly explained. The elements are discussed fully in the text of this research and do not need detailed elucidation.

Care-Connections

In *Care*-Connection the patient is central and the care is delivered in a professional manner through an expression of Active Interest.

Philosophy – Participatory relationships and the primacy of the practical

The philosophy that underpins the ontology and epistemology of this research, is taken from the participatory work of John Heron (1996) and his earlier work on interpersonal helping and counseling, that he subtitles, *A creative practical guid* (1990). It is also the philosophy underpinning the *Care* model. Heron's philosophy explicates the importance of human flourishing (the patient and the RN,) the mutuality of enabling (the RN and the patient) and the 'primacy of the practical' (the RN knowing how).

The caring relationship or the mutuality of enabling is described by Heron (1990) as a combination of 'helping grace' (Heron, 1990, p. 11) and character manifested within the cultural milieu of the helping environment. In expanding the notion of 'helping grace', Heron (1990) indicates that it is a combination of

> …warm concern and the acceptance of the other; openness and atonement to the others experiential reality; a grasp of what the other needs for his or her essential flourishing; an ability to facilitate the realisation of such needs in the right manner and at the right time; and an authentic presence (p.11).

I thought of the common round, the daily task, and students coming in to my office. Unless I have a 'grasp of what the other needs' by taking an Active Interest, I will not be able to help or as Heron puts it, be a part of the students 'essential flourishing'. In taking an Active Interest, as a professional, I should also be gracious, for inherent in the concept of taking an active interest is gracious manner (Heron's 'helping grace'). Or as I indicated earlier, be *pleasant, respectful, interested and responsive.* I know too that some of the students will readily identify the 'warm concern' and 'helping grace' and call it 'caring'. Lecturers who are cool or indifferent may be labeled non-'caring'. I do not take my students home or have a social relationship with them, nor does the RN with the patient – there is simply a *Care* connection.

The 'primacy of the practical' is at the apex of Heron's (1996) epistemological pyramid. Heron asserts that the 'knowing how, is the consummation, the fulfilment, of the knowledge quest' (1996 p. 34). The focal point in this research is the practical issue of enacting *Care*.

Theoretical and practical aspects of the Care* Connection model

In the *Care*-Connection model, the patient is central and the care is delivered in a professional manner through an expression of Active Interest.

Theory

The two theoretical elements of *Care*-Connections are at the same time fused and separate. One is the manner in which the care is delivered and the other is expressed by the RN. The **manner** (whether the RN is other- or self-oriented) is always professional, competent and safe. The care is enacted with appropriate boundaries and behaviour. The **expression** of nursing care is a synthesis of

strategies (nursing care in whatever is needed/prescribed/planned) originating from an Active Interest in the patient and/or family.

The practical interpretation of the *Care*-Connection model with the patient are influenced by person, time and place of the nursing care.

The manner – professional

The criteria of a profession and whether nursing is a fully fledged profession will not be entered into here. What is important is the fact that nursing considers itself to be a profession. Professions are identified by a primary orientation to others (service), professional standards, codes of ethics and professional behaviour, university education and an established career path. *Care* is professional, dictated by soft boundaries and exemplified by behaviour.

A RN is required to meet the nursing registering body's standards of competency, and subscribes to its codes of conduct and ethics. A RN also portrays the foundational concepts of belonging to a profession by being a member of the professional associations, conducting research, putting the patient first and maintaining professional boundaries. *Care* is being able to function with soft boundaries or the ability to be close and distant at the same time.

The concept of service as a professional hallmark is well established; nursing, having assumed the status of a profession, must also 'serve'. Although nursing is a 'new' profession and nurses are increasingly proud of this status, the notion of service is sometimes viewed with suspicion, as historically the term is equated with vocation and dedication.

Professional behaviour/manner is in addition always *pleasant, respectful, interested and responsive.*

The expression – Active Interest

Active Interest is defined as active listening in order to discern the needs in which the other (primarily the patient) becomes the central focus of the nurses' undivided attention.

Active Interest leads to a synergy of enactments. In addition to competent care, Listening, Touch, Going the extra mile, Showing respect to families, and being able to put patients at their Ease are the enactments identified in this research.

Practice

The practice of the *Care*-Connection model is fluid and allows for professional association to develop, and is not dependent on any single factor. The sequences of the connection are intrinsic to the factors related to person, time and place.

Person

There are at least two people involved, the patient and the nurse. Each *Care* connection is as unique as the mix of patients and their families and the RN who are caring for them. Nursing care (to the patient) of the responses (by the nurse) in a professional manner is in essence a result of the Active Interest and Discernment of need.

The patient either perceives care as *Care* (a commercial model) or knows the care is *Care* (an altruistic model) whether the RN knows it or not. In both instances the patient is satisfied with the nursing care.

The RN/nurse in practice can deliver two types of *Care* depending on the nature (and current situation) of the RN. These types of *Care* are not mutually exclusive but both give patient satisfaction. The commercial model is one in which the RN is Self-oriented and the altruistic model is one in which the RN is Other-oriented. (This RN is the *Care* RN of the reflections.) In both these models of care the RN is professionally focused and theoretically the altruistic model is the ideal. Both are dependent on Time and Place.

Time

The time factor is almost as variable as the person factor and is closely related to the illness/disease of the patient and their length of stay in the health care facility. The historic ten day stay of a cholecystectomy has shrunk to an overnight laparoscopic cholecystectomy procedure and in oncology a patient may spend only their last days in palliative care while an elderly patient may spend only months in a frail care home. The time factor in getting to know patients and the formation of a professional connection is critical.

Place

Nursing homes, hospices, day surgery centres, hosphotels and hospital-in-the-home have replaced many hospital beds. The place and time are interdependent. Hospices have longer stay patients and the time in an emergency department may be as short as half an hour.

REFLECTION – the *Care* Connections model

I felt that in making *Care* Connections, the RN is able to apply a practical focus to the sometimes theoretical concept of *Care*. It caters to both those RN who are inherently Caring (Other-oriented) and the RN who are simply there for commercial reasons (Self-oriented). In reality there is an in-between-ness that is a natural part of peoples' personality and the joys and trials that are part of humanity. In spite of my Caring nature, I am irritated today because the cows got into my vegetable patch – this irritation accompanies me to work. However, professionally, I will still show *Care* when dealing with students or patients. Or, as GRN 39 indicates, there is an aspect of personalities that will resonate with some patients and not with others.

> *In watching other nurses I have realized we can not all provide the same type of care as we also care differently which co-insides (sic) with our different nursing styles. GRN 39*

The reflection-on-reflection had been a valuable exercise. I am convinced that *Care* can be taught and that there are strategies that students and nurses can learn. These will make the illness experience one in which patients can 'do well'. It will be a never-ending circle of human flourishing.

Further research and recommendations

While recognising that nurses and patients share a common humanity, and relationships in nursing will continue to be important, the relationship concepts of nursing need to be professionally driven. The singular difference between the pre and post Therapeutic Revolution era is in the extra-ordinary relationships to which patient and nurse are now subject. In the pre-Therapeutic Revolution period, extended lengths of stay in hospital meant patients, over time, could get used to being the 'pyjama-ed' partner in the patient/nurse relationship. In the present clinical milieu the therapeutic relationships of much of the *Care* literature are different.

Quicker and sicker patients need a different Caring, a professional *Care*. In spite of the volumes of research on *Care* there are still areas to be explored.

RECOMMENDATION 1

It is recommended that the *Care*-Connections model be taught to students in undergraduate nursing programs.

It remains within the province of each lecturer in nursing to make the choices as to the method with which they are most comfortable and effective. Jean Watson (1990) comments that "…we have to realize that education is finally and ultimately a human experience and human act for which there can be no final agreement or answers" (p. xiv). The human experience and human act of teaching, especially *Care*, cannot be prescribed. Good teaching is imbedded in the person, and it is only as the pupil responds to the humanity of the teacher that deep and lasting learning will occur.

This model can be taught as a professional outworking of the ethical standards and codes of conduct of the profession as well as a life principle to be practised.

RECOMMENDATION 2

It is recommended that the *Care*-Connections model be used as a management tool to increase the *Care* in the clinical milieu.

Care on a practice level needs to ensure that RN are placed where they think they can best nurse and/or management places the *Care* RN where they have been tested to do best. Not all RN have entered nursing as a vocation. The *Care* Connections model can be used to give an understanding of the importance of *Care* and used as a tool to educate the present workforce on *Care*. The centrality of the patient and the need for a professional expression of *Care* through the elements as depicted in the model will give both an understanding of the concept as well as how *Care* can be enacted. In this manner *Care* can be accorded its rightful place in nursing in the 21st Century.

RECOMMENDATION 3

It is recommended that the *Care*-Connections model be used to explore the relationship between RN personalities and their effectiveness in different areas of the clinical milieu.

The relationship of the personality of the RN to *Care* is an area beyond the scope of this research. While this notion is possibly new to nursing, it is not new to vocational guidance psychologists. Nursing will attract, for the most part, those who want to be part of a helping profession. Specialities in nursing require different levels of 'helping', compassion or concern. Very broadly, the Other-oriented RN will probably do better in areas of long term care, such as palliative care, while the Self-oriented RN will do better in areas such as operating theatre.

Further Research

- There is an important area of patient satisfaction – research on the individualisation of nursing care and the resulting satisfaction
- There are challenges/problems within the teaching of undergraduate nursing students that need to be explored. They include some of the reflexive aspects of this research that have surfaced and need to be researched and determined. They are:
    - Using texts with a nursing diagnosis framework that has no direct correlation with the practice/hospital setting where nursing diagnoses are not used.
    - Texts continue to be prescriptive and the challenge to correlate the individualisation of the patient and the learning needs of the student in nursing need to be explored.

Strengths and Limitations

Ultimately the judgement about the strength and limitations of this research must be left to others to decide. The immersion in the research for years blinds the researcher, particularly to the faults. However, most research contains a section where the researcher stands back and makes a personal judgement. After all, the researcher is closest to the research and some of the forte and faults may possible be more easily seen by the researcher. In keeping with the participatory paradigm and

the reflexivity and reflections used in this research, the strengths and limitations will be written in the form of a reflection.

EPILOGUE

SOME DAY,
AFTER WE HAVE MASTERED
THE WIND, THE WAVES,
THE TIDES AND GRAVITY
WE SHALL HARNESS THE ENERGIES
OF LOVE.
THEN, FOR THE SECOND TIME
IN THE HISTORY OF THE WORLD,
MAN WILL HAVE DISCOVERED
FIRE.

Peirre Teilhard de Chardin

(1881-1955)

We cannot master the wind, waves, tide, and gravity …

Nor can we harness the energies of love.

Or can we?

… There *are* 'energies' of love.

They are multiple and cannot be counted, calculated, categorised or even estimated.

Biographies and autobiographies tell the stories of the indomitable human spirit as the love energises people to come to terms with the harsh realities of disabling disease or the rigours of coping with chronicity.

BUT …

there are also the untold sagas of ordinary individuals, ex-patients who have come against similar odds and, not only survived, but lived full and satisfying lives.

Usually unsung, it is *Care* which has facilitated, enabled, and strengthened the resolve of many patients to harness their own energies of love.

There is a challenge to nursing that is urgent and cannot be disregarded. Although the need for high technology will remain, so too will the need for Caring nurses remain. While it cannot be predicted how the technology of the future will progress, the way in which nurses are prepared for practice can be decided. The perceived historical dedication and devotion will remain just that – historical. However, the synonymity of nursing and caring, *Care*, in all its interpretations, must be maintained. The patient must be at the centre, with nurses taking an Active Interest. An ability to listen, to respect families and put patients at their ease, while being professional and maintaining professional standards, must be at the heart of all nursing practice and education.

The tides of nursing education are uncertain, but the *Care* essence will always remain. How nursing harnesses this *Care* is up to the profession. *Care* Connections is one way to both show and teach caring in nursing.

A FINAL REFLECTION

I am reflecting with joy and sadness. It is, like the other reflections, something of me, and thus part of the reflexivity of the paradigm.

The participatory paradigm, the formal incorporation of the GRN and their view of *Care* and the enactments that they were asked to reflect is unique. It is a major strength of this research. The fact that the GRN were not being researched and that they were an active part of what is sometimes called the data collection, made the viewing of *Care* particularly neutral. I was excited with the responses and still am and want to use the information in further research.

The formal expert group who met with me as part of the participatory model meant that the criticism of the research was more than the usual collegial exchanges that one has when researching. The advice had to be taken; it could not be shrugged off. The return to the education literature and the teaching of

Care was a profitable exercise that need not necessarily have been done if the group had not been part of the method.

I enjoyed the growth in my writing and in many respects looked forward to the weekends. I was able to take time out with the family, so it was not as onerous as I thought it might be. Although I am so close to the writing now I hope that some of the enjoyment of writing comes through to the reader and trust that this too is a strength.

The limitations are not hard to see.

The reflections are perhaps too personal. I had to take some out, as the word length was increasing well beyond the prescribed limit. Perhaps I could have left some in and taken out other material. I wonder.

I possibly tried to put too much into the thesis itself and the reader may be overwhelmed by the information. I have always tried to see things from a different perspective and this too may put the reader offside. I am also an idealist and, as *Care* is my passion, this research could be too idealistic.

There is a mixture of joy and sorrow that I have finished.

There is also sorrow as I have just returned from the funeral of one of the six GRN who had participated in the Dialogue day at our home. Anne died after a short eight month fight with cancer of the liver. There is sorrow at the loss of her young life and sorrow that she will not have the joy of seeing her name in the acknowledgements.

Conclusion

I felt humble as I finally reflected on the paths I had travelled, the profound writings that I had found and read, the insights that I had had and the lessons learned. Caring and *Care* were still elusive subjects.

References

Allmark, P. (1998). Is Caring A Virtue? *Journal of Advanced Nursing, 28*(3 (Sep), 466-472.

ANRAC Competency Project. (1990). *ANRAC National Competencies* (No. ANRAC1990). Adelaide: Australasian Nurse Registering Authorities Conference.

Aranda, S. K., & Street, A. F. (1999). Being authentic and being a chameleon: nurse-patient interaction revisited. *Nursing Enquiry, 6*(2), 75-82.

Armstrong, S., & Warlick, D. (2004). The New Literacy - The 3Rs Evolve into the 4Es. *Technology & Learning*, 20-28.

Arndt, M. J. (1992). Caring as everydayness. *Journal of Holistic Nursing, 10*(4), p285, 9 pages.

Augustine, S. (1969). *St. Augustine On Education* (G. Howie, Trans. First ed.). U.S.A.: Henry Regnery Company.

Baly, M. (1997). *As Miss Nightingale Said...* (Second ed.). London: Balliere Tindall.

Barr, W. J., & Bush, H. A. (1998). Applied Research. Four Factors Of Nurse Caring In The ICU. *Dccn:-Dimensions Of Critical Care Nursing (Dccn), 17*(4 July - Aug 1998), 214-223.

Bates, E., & Lapsley, H. (1985). *The Health Machine*. Melbourne: Penguin Books Australia.

Baumann, A. O., Deber, R. B., Silverman, B. E., & Mallette, C. M. (1998). Who cares? Who cures? The ongoing debate in the provision of health care. *Philosophical and ethical issues, 28*(5), 1040-1045.

Baume, P. (1998). Current Distortions. In P. Baume (Ed.), *The Tasks of Medicine-An Ideology of Care* (pp. 199-209). Sydney: MacLennan + Petty.

Beck, C. T. (1999). Quantitative Measure Of Caring. *Journal of Advanced Nursing (J-Adv-Nurs) 30(1)*(July 1999), 24 -32.

Beddoe, S. S. (1999). Reachable Moment. *Image: Journal of Nursing Scholarship, 31*(3), 248.

Bellach, J. P. (1999). Emotional Intelligence: A Missing Ingredient? *Journal of Nursing Education, 38*(1 (Jan)), 3 - 4.

Benner, P. (1984). *From Novice To Expert -Excellence And Power In Clinical Nursing Practice*. Menlo Park: Addison-Wesley.

Benner, P. (2004). Relational Ethics of Comfort, Touch, and Solace - Endangered Arts? *American Journal of Critical Care, 13*(4), 346-349.

Benner, P., & Wrubel, J. (1989). *The Primacy Of Caring-Stress And Coping In Health And Illness*. Menlo Park: Addison-Wesley.

Benner, P., & Wrubel, J. (2002). Response to: 'Edwards, Benner and Wrubel on caring' by S. Horrocks (2002) Journal of Advanced Nursing 40, 36-41. *Journal of Advanced Nursing, 40*(1), 45-47.

Bennett, P. M., Porter, B. D., & Sloan, R. S. (1989). Jean Watson: Philosophy and Science of Caring. In Marriner-Tomey (Ed.), *Nursing Theorists and Their Work* (Second Edition ed., pp. 164-173). St Louis: C.V. Mosby Company.

Bevis, E. O. (1989). *Curriculum Building in Nursing a Process* (Third Edition ed.). New York: National League for Nursing.

Bevis, E. O. (1989a). Illuminating the Issues: Probing the past, a history of nursing curricula development-- The past shapes the present. In E. O. Bevis & J. Watson (Eds.), *Toward a caring curriculum: a new pedagogy for nurses.* (pp. 13-33). New York: National League for Nursing.

Bevis, E. O. (1989b). Nursing curriculum as professional education: some underlying theoretical models. In E. O. Bevis & J. Watson (Eds.), *Toward a caring curriculum: a new pedagogy for nurses.* (pp. 67-105). New York: National League for Nursing.

Bevis, E. O. (1989c). Teaching and learning: a practical commentary. In E. O. Bevis (Ed.), *Toward a caring curriculum: a new pedagogy for nurses.* (pp. 217-259). New York: National League for Nursing.

Bevis, E. O. (1989d). Teaching and learning: the key to education and professionalism. In E. O. Bevis & J. Watson (Eds.), *Toward a caring curriculum: a new pedagogy for nurses.* (pp. 153-188). New York: National League for Nursing.

Bishop, A. H. (1996). The nature of nursing: natural or conventional? In J. F. Kikuchi, H. Simmons & D. Romyn (Eds.), *Truth in Nursing Inquiry* (pp. 88-97). Thousand Oaks: Sage Publications.

Bjork, I. T. (1997). Changing Conceptions Of Practical Skill Acquisition In Nursing Education. *Nursing Inquiry, 4*(3 (Sept)), 184-195.

Bjork, I. T. (1999). What Constitutes A Nursing Practical Skill?...Including Commentary By Romyn, D.M. *Western Journal Of Nursing Research, 21*(1 (Feb)), 51 -70.

Bjork, I. T., & Kirkevold, M. (2000). From simplicity to complexity: developing a model of practical skill performance in nursing. *Journal of Advanced Nursing, 9*(4), 620-631.

Blattner, B. (1981). *Holistic Nursing*. Englewood Cliffs: Prentice Hall.

Borda, O. F. (2001). Participatory (Action) Research in Social Theory: Origins and Challenges. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research* (pp. 27-37). London: SAGE Publications.

Borttorff, J. (1995). Comforting: exploring the work of cancer nurses. *Journal of Advanced Nursing, 22*, 1077-1084.

Bottoroff, J. L. (1991). Nursing: a practical science of caring. *Advances in Nursing Science, 14*(1), 26-39.

Boughn, S. L. A. (1999). Why Do Women Choose Nursing? *Journal Of Nursing Education, 38*(4), 156-161.

Bradshaw, A. (1997). Defining 'competency' in nursing (Part I): a policy review. *Journal of Advanced Nursing, 6*, 347-354.

Bradshaw, A. (1998). Defining 'competency' in nursing (Part II): an analytical review. *Journal of Advanced Nursing, 7*, 103-111.

Bradshaw, A. (1999). The virtue of nursing: the covenant of care. *Journal of Medical Ethics, 25*(6), 1-7.

Bray, J. N., Lee, J., Smith, L. L., & Yorks, L. (2000). *COLLABORATIVE INQUIRY IN PRACTICE Action, Reflection, and Meaning Making*. Thousand Oaks: Sage Publications, Inc.

Brooks, P. (1998). Caring for the sick. In P. Baume (Ed.), *The tasks of Medicine-an Ideology of Care* (pp. 3-13). Sydney: MacLennan + Petty.

Buchan, J. (1992). Cost -effective Caring. *International Nurse Review, 39*(4), 117-120.

Burchill, E. (1985). *The Paths I've Trod*. Melbourne: Spectrum.

Caelli, K. (2001). Aspects of Caring in Australian nursing. *Collegian, 8*(1), 26-32.

Calder, J. M. (1955). *The Story of Nursing*. London: Methuen & Co. Ltd.

Califano, J. A. (1986). *America's Health Care Revolution. Who lives? Who dies? Who pays?* New York: Random House, Inc.

Campbell, A. V. (1984). *Moderated Love-A theology of Professional Care*. London: SPCK.

Carper, B. A. (1978). Fundamental Patterns of Knowing in Nursing. *Advances in Nursing Science, 1*(1), 252-260.

Centre, H. I. (1988). *What's Wrong with the Health System?* (Issues Paper). Melbourne: Health Issues Centre.

Charlesworth, M. (1998). The politics of bioethics. In P. Baume (Ed.), *The Tasks of Medicine: an ideology of Care* (pp. 116-130). Sydney: MacLennan + Petty.

Cheung, J. (1998). Caring as the ontological and epistemological foundations of nursing: A view of caring from the perspectives of Australian nurses. *International Journal of Nursing Practice, 4*, 225-233.

Chiarella, M. (2002). *The legal and professional status of nursing.* Edinburgh: Churchill Livingstone.

Ching, M. (1993). The use of touch in nursing practice. *The Australian Journal of Advanced Nursing, 16*(4), 4-9.

Chinn, P. L. (1994). Developing a method for aesthetic knowing in nursing. In P. L. Chinn & J. Watson (Eds.), *Art and Aesthetics in Nursing* (pp. 19-40). New York: National League for Nursing Press.

Clarke, J. B., & Wheeler, S. J. (1992). A view of the phenomena of caring in nursing practice. *Journal of Advanced Nursing, 17*(11), 1283-1290.

Collinson, V., & Killeavy, M. (1999). Exemplary teachers: Practicing an ethic of care in England, Ireland, and the United States. *Journal for a Just and Caring Education, 5*(4), 349.318pages.

Cordia, M. (1990). *Nurses at Little Bay*. Sydney: Prince Henry Trained Nurse Association.

Cortis, J. D., & Kendrick, K. (2003). Nursing Ethics, Caring and Culture. *Nursing Ethics, 10*(1), 78-88.

Costa, A. L. (1999). Foreword. In M. Z. Solomon (Ed.), *The Diagnostic Teacher: Constructing new approaches to professional development* (pp. vii-xv). New York: Teachers College Press.

Cowell, D. (1975). The practice of nursing - Psychiatric care. *The Australian Nurses' Journal, 5*(3), 9-12.

Cowin, L., & Jacobsson, D. (2003). The nursing shortage: part way down the slippery slope. *Collegian, 10*(3), 31-35.

Coyle, J., & Williams, B. (2000). An exploration of the epistemological intricacies of using qualitative data to develop a quantitative measure of user views of health care. *Journal of Advanced Nursing, 31*(5), 1235-1243.

Crisp, J., & Taylor, C. (2001). *Potter and Perry's fundamentals of nursing*. Sydney: Mosby.

Curry, G. (1995). Humanities, scholarly wisdom and nursing practice. In G. Gray & R. Pratt (Eds.), *Scholarship in the discipline of nursing* (pp. 227-242). Melbourne: Churchill Livingstone.

Davies, E. (1993). Clinical role modelling: uncovering hidden knowledge. *Journal of Advanced Nursing, 18*, 627-636.

Dawson, W. R. (1998). *Extensions to Bloom's Taxonomy of Educational Objectives*. Putney: Putney Publishing.

Denzin, N. K., & Lincoln, Y. S. (2000). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed., pp. 1-29). Thousand Oaks: Sage Publications. Inc.

Diers, D. B. J. (1997). Nursing Resources Definition in DRGs. Rims\Nursing Acuity Project Group. *Nursing Economic$, 15*(3), 124-130, 137.

Digby, A. (1997). The Patient's View. In I. Loudon (Ed.), *Western Medicine - an illustrated history* (pp. 291-305). Oxford: Oxford University Press.

Dobson, M. (1997). Epidemics and the geography of disease. In I. Loudon (Ed.), *Western Medicine- an illustrated history* (pp. 176-191). New York: Oxford University Press.

Doherty, M. K., Sirl, M. B., & Ring, O. I. (1954). *Modern Practical Nursing Procedures*. Sydney: Dymocks Book Arcade Ltd.

Dolan, J. A. (1973). *Nursing in Society: a historical perspective* (13th edition ed.). Philadelphia: W. B. Saunders Company.

Donahue, M. P. (1985). *NURSING. The finest art-an illustrated history*. St. Louis: C.V. Mosby Company.

Dossey, B. M. (1995). Nurse as Healer. In B. M. Dossey, L. Keegan, C. E. Guzzetta & L. G. Kolkmeire (Eds.), *Holistic Nursing A Handbook for Practice* (Second Edition ed., pp. 61-81). Gaithersburg: Aspen Publishers, Inc.

Dreary, V. D., I. McKenna, H. P. McAnce, T. Watson, R. Hoogbruin, A.L. (2002). Elisions in the field of caring. *Journal of Advanced Nursing, 39*(1), 96-102.

Dunlop, M., J. (1986). Is a science of caring possible? *Journal of Advanced Nursing, 11*, 661-670.

Dycus, D. K., Schmeiser, D. N., Taggart, F. M., & Yancey, R. (1989). Faye Glenn Abdellah: Twenty-one Nursing Problems. In A. Marriner-Tomey (Ed.), *Nursing Theorists and Their Work* (Second Edition ed., pp. 93-108). St Louis: The C.V. Mosby Company.

Dyson, J., Cobb, M., & Forman, D. (1997). The meaning of spirituality: a literature review. *Journal of Advanced Nursing, 26*, 1183-1188.

Eikeland, O. (2001). Action Research as the Hidden Curriculum of the Western Tradition. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research* (pp. 145-155). London: SAGE Publications.

Elkin, M. K., Perry, A. G., & Potter, P. A. (1996). *Nursing Interventions and Clinical Skills*. St Louis: Mosby-Year Book Inc.

Ellard, J. (1998). Healers and their Society. In P. Baume (Ed.), *The Tasks of Medicine-an ideology of Care* (pp. 46-59). Sydney: MacLennan + Petty.

Endo, E., Nitta, N., Inayoshi, M., Saito, R., Takemura, K., Minegishi, H., et al. (2000). Pattern recognition as a caring relationship in families with cancer. *Journal of Advanced Nursing, 32*(3), 603-610.

English, I. (1993). Intuition as a function of the expert nurse: a critique of Benner's novice to expert model. *Journal of Advanced Nursing, 18*, 387-393.

Eriksson, K. (1994). Theories of Caring as Health. In D. A. Gaut & A. Boykin (Eds.), *Caring As Healing-Renewal Through Hope* (pp. 3-20). New York: National League For Nursing.

Estabrooks, C. A., & Morse, J. M. (1992). Toward a theory of touch: the touching process and acquiring a touching style. *Journal of Advanced Nursing, 17*, 448-456.

Fagerstrom, L. (1998). Measuring the unmeasurable: a caring science perspective on patient classification. *Journal of Nursing Management, 6*, 165-172.

Fagerstrom, L., Eriksson, K., & Engberg, I. B. (1998). The patient's perceived caring needs as a message of suffering. *Journal of Advanced Nursing, 28*(5), 978-987.

Farmer, E. (1992). Promoting caring in nursing. (Editorial). *British Journal of Nursing, 1*(11), 537.

Faust, C. H. (1969). The Second Lynam Bryson Lecture: Some reflections on Education and the formation of Character. In C. H. Faust & J. Feingold (Eds.), *Approaches to Education for Character--Strategies for change in higher education* (pp. 378-395). New York: Columbia University Press.

Fitzgerald, L., & van Hooft, S. (2000). A Socratic Dialogue on the Question 'What is Love in Nursing? *Nursing Ethics, 7*(6), 481-491.

Flanagan, L. (1997). Staff nurses: Who are they, what do they do and what challenges do they face? In J. C. McCloskey & H. Grace, K. (Eds.), *Current issues in nursing* (Fifth Edition ed., pp. 13-17). St Louis: Mosby.

Fletcher, J. (1997). Do Nurses Really Care? Some Unwelcome Findings From Recent Research And Inquiry. *Journal of Nursing Management, 5*(1), 43-50.

Fosbinder, D. (1994). Patient perception of nursing care: an emerging theory of interpersonal competence. *Journal of Advanced Nursing, 20*, 1085-1093.

Fredriksson, L. (1999). Modes of relating in a caring conversation: a research synthesis on presence, touch and listening. *Journal of Advanced Nursing, 30*(5), 1167-1176.

Fredriksson, L., & Eriksson, K. (2003). The Ethics of the Caring Conversation. *Nursing Ethics, 10*(2), 138-148.

Gagne, R. M., Briggs, L. J., & Wager, W. W. (1992). *Principles of Instructional Design* (Fourth Edition ed.). Belmont: Wadsworth Thomson Learning.

Gardner, A., Goodsel, J., Duggan, T., Murtha, B., Peck, C., & Williams, J. (2001). 'Don't call me sweetie!': Patients differ from nurses in their perceptions of caring. *Collegian, 8*(3), 32-38.

Gardner, G. (2000). Hospital and Home - Strange bedfellows or new partners. *Collegian, 7*(1), 9-15.

Gastmans, C. (1998). Challenges to Nursing Values in a Changing Nursing Environment. *Nursing Ethics, 5*(3), 236-245.

Glass, N., & Walter, R. (2000). An experience of Peer mentoring with student nurses: Enhancement of personal and professional growth. *Journal of Nursing Education, 39*(4), 155-160.

Goleman, D. (1996). *Emotional Intelligence - Why it can Matter More than IQ*. London: Bloomsbury.

Goleman, D. (1999). *Working with Emotional Intelligence* (Paperback Edition ed.). London: Bloomsbury.

Gramling, L., & Nugent, K. (1998). Teaching Caring Within The Context Of Health. *Nurse Educator, 23*(2 (Mar-Apr)), 47-51.

Grams, K., Kosowski, M., & Wilson, C. (1997). Creating A Caring Community In Nursing Education. *Nurse Educator, 22*(3 (May-June)), 10-16.

Greenhalgh, J., Vanhaned, L., & Kyngas, H. (1998). Nurse Caring Behaviours. *Journal of Advanced Nursing, 27*(5), 927-932.

Grindle, N. C., & Dallat, J. (2001). Northern Island--State of the Arts? An evaluation of the use of the arts in teaching caring. *Nurse Education Today, 21*, 189-196.

Grippando, G. M., & Mitchell, P. R. (1989). *Nursing Perspectives and Issues* (4th Edition ed.). New York: Delmar Publishers Inc.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. In N. K. Denzin & Y. Lincoln (Eds.), *Book of Qualitative Research*. Thousand Oaks: Sage Publications.

Guzzetta, C. E. (1995). Holistic Approach to the Nursing Process. In B. M. Dossey, L. Keegan, C. E. Guzzetta & L. G. Kolkmeire (Eds.), *Holistic Nursing. A Handbook for Practice* (2nd Edition ed., pp. 155-193). Gaithersburg: Aspen Publishers, Inc.

Hall, B. L. (2001). I wish this were a poem of practice of participatory research. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research* (pp. 171-178). London: SAGE Publications.

Hammer, S., Norton, P., & Star, C. (2004, June 14 2004). Cheating to cope in the hothouse. *THE Australian*, p. 42.

Hank, P. (2000). *The New Oxford Thesaurus Of English*. New York: OXFORD University Press.

Happell, B. (2001). Professional Nursing Roles. In J. Crisp & C. Taylor (Eds.), *Potter & Perry's Fundamentals of Nursing* (pp. 375-398). Sydney: Mosby.

Harris, W. T. (Ed.). (1934). *Websters New International Dictionary of the English Language*. Springfield: B&C Morrison Co.

Hartrick, G. (1997). Relational Capacity: The Foundation For Interpersonal Nursing Practice. *Journal of Advanced Nursing, 26*(3 (Sep)), 523-528.

Hartrick, G. (1999). Transcending Behaviourism In Communication Education. *Journal of Nursing Education, 38*(1 (Jan)), 17 - 22.

Havener, W. H. (1979). *Synopsis of OPHTHALMOLOGY* (FIFTH EDITION ed.). St Louis: The C.V. Mosby Company.

Heath, P. (2002). *National Review of Nursing Education 2002- Our Duty of Care*. Canberra: Commonwealth of Australia.

Hegedus, K. S. (1999). Providers' and consumers' perspective of nurses' caring behavior. *Journal of Advanced Nursing, 30*(5), 1090-1096.

Hegney, D., Plank, A., & Parker, V. (2003). Workplace violence in nursing in Queensland, Australia: a self-reported study. *International Journal of Nursing Practice, 9*, 261-268.

Helfand, W. H. (2000). *The Nightingales Song-Nurses and Nursing in the ARS Medica Collection of the Philadelphia Museum of Fine Art*. Philadelphia: Philadelphia Museum of Art.

Heron, J. (1990). *Helping the Client A creative practical guide*. London: Sage Publications Ltd.

Heron, J. (1996). *Co-operative Inquiry: Research into the Human Condition*. Thousand Oaks: Sage Publications, Inc.

Heron, J., & Reason, P. (1997). A Participatory Inquiry Paradigm. *Qualitative Inquiry, 3*(3), 247-268.

Heron, J., & Reason, P. (2001). The Practice of Co-operative Inquiry: Research 'with'' rather than 'on' People. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research*. London: SAGE Publications.

Heskins, F. M. (1997). Exploring Dichotomies Of Caring, Gender And Technology In Intensive Care Nursing: A Qualitative Approach. *Intensive and Critical Care Nursing, 13*(2 (Apr)), 65-71.

Hobble, W. H., Lansinger, T., & Magers, J. A. (1989). Joyce Travelbee: Human to Human Relationship Model. In Marriner-Tomey (Ed.), *Nursing Theorists and Their Work* (Second Edition ed., pp. 219-227). St Louis: C.V. Mosby Company.

Horrocks, S. (2002). Edwards, Benner and Wrubel on caring. *Journal of Advanced Nursing, 40*(1), 36-41.

Hyrkas, K., & Paunonen, M. (2000). Patient satisfaction and research-related problems (part 2). Is triangulation the answer? *Journal of Nursing Management, 8*, 237-245.

Hyrkas, K., Paunonen, M., & Laippala, P. (2000). Patient satisfaction and research related problems (part1). Problems using questionnaires and the possibility to solve them by using different methods of analysis. *Journal of Nursing Management, 8*, 227-236.

Irurita, V. F. (1999). Factors affecting the quality of nursing care: The patient's perspective. *International Journal of Nursing Practice, 5*, 86-94.

Iwasiw, C. L., & Goldenberg, D. (1993). Peer teaching among nursing students in the clinical area: effects on student learning. *Journal of Advanced Nursing, 18*, 659-668.

Jaeger, S., M. (2001). Teaching health care ethics: the importance of moral sensitivity for moral reasoning. *Nursing Philosophy, 2*, 131-142.

Jenlick, P. M., & Kinnucan-Welsch, K. (1999). Learning ways of caring, learning ways of knowing through communities of professional development. *Journal for a Just and Caring Education, 5*(4), p367 319p.

Johnstone, M. (1994). *Bioethics a nursing perspective* (second edition ed.). Sydney: W.B. Saunders.

Johnstone, M. (1999). *Bioethics a nursing perspective* (third edition ed.). Sydney: Harcourt Saunders.

Johnstone, M. (2004). *Bioethics: a nursing perspective* (fourth edition ed.). Sydney: Churchill Livingstone.

Joudrey, R., & Gough, J. (1999). Caring And Curing Revisited: Student Nurses' Perceptions Of Nurses' Perceptions Of Nurses' And Physicians' Ethical Stances. *Journal of Advanced Nursing', 29*(5 (May)), 1154-1162.

Kelly, B. (1998). Preserving moral integrity: a follow-up study with new graduates. *Journal of Advanced Nursing, 28*(5), 1134-1145.

Kelly, J. (2004). Accountability and Recent Developments in Nursing - Be Bold, Be Holistic. A review of the literature. *Dimensions of Critical Care Nursing, 23*(1), 31-37.

Kemmis, S., & McTaggart, R. (2000). Participatory Action Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (2nd ed. ed.). Thousand Oaks: Sage Publications, Inc.

Kemp, M. (1997). Medicine in view: art and visual representation. In I. Loudon (Ed.), *Western Medicine- an illustrated history* (pp. 1-25). Oxford: Oxford University Press.

Kosowski, M. M. R. (1995). Clinical Learning Experiences and Professional Caring: A Critical Phenomenological Study of Female Baccalaureate Nursing Students. *Journal of Nursing Education, 34*(5), 325-242.

Kramer, M. (1974). *Reality shock: why nurses leave nursing*. St. Louis: C.V. Mosby.

Kramer, M. K. (1990). Holistic Nursing: Implications for knowledge development and utilisation. In Chaska. N.L. (Ed.), *The Nursing Profession: turning points.* (pp. 245-262). St. Louis: C.V. Mosby Company.

Krathwohl, D. R. (1994). Reflections on the taxonomy: Its Past, Present, and Future. In L. W. Anderson & L. A. Sosniak (Eds.), *Bloom's Taxonomy A Forty-year Retrospective Ninety-third Yearbook of the National Society for the Study of Education* (pp. 181-202). Chicago: The National Society for the Study of Education.

Krathwohl, D. R., Bloom, B. S., & Masia, B. B. (1964). *Taxonomy of Educational Objectives-The classification of educational goals. Handbook II: Affective Domain*. New York: David McKay Company, Inc.

Larkins, R. (1998). Advances in Disease Treatment. In P. Baume (Ed.), *The Tasks of Medicine- An Ideology of Care* (pp. 168-182). Sydney: MacLennan + Petty.

Larsson, G., Widmark, V., Lampic, C., Von-Essen, L., & Sjoden, P. (1998). Cancer Patient And Staff Ratings Of The Importance Of Caring Behaviours And

Their Relations To Patient Anxiety And Depression. *Journal of Advanced Nursing, 27*(4), 855-864.

Lawler, J. (1991). *Behind the Screens-nursing, somology, and the problem of the body*. Melbourne: Churchill Livingstone.

Lawler, J. (1995). Foreword. In G. Gray & R. Pratt (Eds.), *Scholarship in the discipline of nursing* (pp. v-vii). Melbourne: Churchill Livingstone.

Lea, A., Watson, R., & Dreary, I. J. (1998). Caring in nursing: a multivariate analysis. *Journal of Advanced Nursing, 28*(3), 662-671.

Lewis, C. S. (1998). *The Four Loves*. London: HarperCollins (Fount).

Lewis, J. (1997). Medicine, Politics, and the State. In I. Loudon (Ed.), *Western Medicine* (pp. 277-290). Oxford: Oxford University Press.

Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretative research. *Qualitative Inquiry, 1*(3), 275-290.

Lincoln, Y. S., & Guba, E. G. (2000). Paradigmatic Controversies, Contradictions, and Emerging Confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Handbook of Qualitative Research* (2nd ed., pp. 163-188). Thousand Oaks: Sage Publications, Inc.

Lindeman, C. (1999). The art of nursing. *Creative Nursing, 5*(3), 2 pages.

Locsin, R. C. (1997, 1997). *Knowing the whole person: Revolutionizing nursing practice.* Paper presented at the Connecting Conversation: Nursing Scholarship and Practice, Reykjhavik. Iceland.

Loudon, I. (Ed.). (1997). *Western Medicine- an Illustrated History*. Oxford: Oxford University Press.

Macdonald, J. (1993). The caring imperative: a must? *The Australian Journal of Advanced Nursing, 11*(1), 26-30.

Mager, R. F. (1975). *Preparing Instructional Objectives* (Second Edition ed.). Belmont: Fearon Publishers Inc.

Marriner-Tomey, A. (Ed.). (1989). *Nursing Theorists and their Work* (Second Edition ed.). St Louis: The C. V. Mosby Company.

Martin-McDonald, K. (2000). *Finding meaning in being Dialysis-Dependent: a Constructivist Perspective.* Unpublished Doctorate of Philosophy, University of Southern Queensland, Toowoomba.

Martsolf, D. S., & Mickley, J. R. (1998). The concept of spirituality in nursing theories: differing world-views and extent of focus. *Journal of Advanced Nursing, 27*(2), 294-303.

Mayer, J. D. (2001). Emotion, Intelligence, and Emotional Intelligence. In J. P. Forgas (Ed.), *Affect and Social Cognition* (pp. 410-431). Sydney: Lawrence Erlbaum Associates, Publishers.

Mayer, J. D., & Salovey, P. (1997). What is Emotional Intelligence? In P. Salovey & D. J. Sluyter (Eds.), *Emotional Development and Emotional Intelligence: educational implications* (pp. 3-31). New York: Basic Books.

Mayeroff, M. (1971). *On Caring*. New York: Harper and Rowe.

McCance, T. V., McKenna, H. P., & Boore, J. R. P. (1999). Caring: theoretical perspectives of relevance to nursing. *Journal of Advanced Nursing, 30*(6), 1388-1395.

McCrea, M. A., Atkinson, M., Bloom, T., Merkh, K., I.I., N., & Smith, C. (2003). The Healing Energy of Relationships - A journey to excellence. *Nursing Administration Quarterly, 27*(3), 240-248.

McEwen, M. (2000). Teaching Theory at the Master's Level: Report of a National Survey of Theory Instructors. *Journal of Professional Nursing, 16*(6), 354-361.

Miller, W. L., & Crabtree, B. F. (1994). Clinical Research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 340-352). Thousand Oaks: Sage Publications.

Miller, W. L., & Crabtree, B. F. (2000). Clinical research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The handbook of qualitative research* (2nd ed., pp. 607-631). Thousand Oaks: Sage Publications, Inc.

Minchin, M. K. (n.d.). *Revolutions and Rosewater The evolution of nurse registration in Victoria 1923-1973*. Melbourne: Victorian Nursing Council.

Mohr, W. K., Deatrick, J., Richmond, T., & Mahon, M. M. (2001). A Reflection on Values in Turbulent Times. *Nursing Outlook, 49*(1), 30-36.

Moore, B. (Ed.). (1999). *The Australian Oxford Dictionary*. Melbourne: OXFORD University Press.

Morse, J. (1992). Comfort. *Clinical Nursing Research, 1*(1), p91, 16p.

Morse, J. M. (1992). The refocusing of nursing care. *Clinical Nursing Research, 1*(1), 91-107.

Morse, J. M. (1994). The phenomenology of comfort. *Journal of Advanced Nursing, 20*, 189-195.

Morse, J. M., Borttorff, J., Neader, W., & Solberg, S. (1994). Comparative Analysis of Conceptualisations and Theories of Caring. In E. C. Hein & M. J.

Nicholoson (Eds.), *Contemporary Leadership Behavior: Selected Readings* (Vol. Fourth Edition, pp. 25-41): J. B. Lippincott Company.

Murray, M. (1976). *Fundamental of Nursing*. Englewood Cliffs: Prentice-Hall Inc.

Nelms, T. P. (1990). The lived experience of nurse education: a phenomenological study. In M. Leininger & J. Watson (Eds.), *The Caring Imperative in Education* (pp. 285-297). New York: National League for Nursing.

Nouwen, H. (1989). *Seeds of Hope*. London: Darton, Longman and Todd Ltd.

Nouwen, H. J. M. (1979). *The Wounded Healer - Ministry in Contemporary Society* (Image edition ed.). New York: Doubleday.

Nouwen, H. J. M. (1992). *The way of the heart* (2nd ed. ed.). London: Darton, Longman and Todd.

O'Keefe, B. (2004, 10/11/04). Something in return for tales of woe. *The Australian*, p. 23.

Olson, T. C. (1993). Laying claim to Caring: Nursing and the language of training, 1915-1937. *Nursing Outlook, 41*(2), 68-72.

Orem, D. E. (1985). *Nursing- Concepts of practice* (Third Edition ed.). New York: McGraw - Hill.

Owen, S. (1993). Identifying a role for the nurse teacher in the clinical area. *Journal of Advanced Nursing, 18*, 816-825.

Paley, J. (1996). Intuition and Expertise: comments on the Benner debate. *Journal of Advanced Nursing, 23*, 665-671.

Paley, J. (2001). An archeology of caring knowledge. *Journal of Advanced Nursing, 36*(2), 188-198.

Paley, J. (2002). Caring as a slave morality: Nietzschean themes in nursing ethics. *Journal of Advanced Nursing, 40*(1), 24-35.

Paniagua, H. (2004). Can the underlying principles of art be applied to nursing? *British Journal of Nursing, 13*(4), 220-223.

Park, K. (1997). Medicine and the Renaissance. In I. Loudon (Ed.), *Western Medicine - An Illustrated History* (pp. 66-80). Oxford: Oxford University Press.

Parker, J. (1999). Patient or customer? *Collegian, 6*(1), 17-23.

Parker, J. (2000). The art and science of nursing. In Daly. J., Speedy. S. & Jackson. D. (Eds.), *Contexts of nursing-an Introduction* (pp. 25-37). Sydney: MacLennan & Petty.

Parse, R. R. (1981). *Man-Living-Health-A theory of nursing*. New York: John Wiley and Sons.

Patistea, E., & Siamanta, H. (1999). A literature review of patients' compared with nurses' perceptions of caring: Implications for

practice and research. *Journal of Professional Nursing, 15*(5), 302-312.

Pattison, S. (2001). Are Nursing Codes of Practice Ethical? *Nursing Ethics, 8*(1), 5-18.

Patton, J., & Woods, S. J. (1995). *Senior nursing student's perceptions of care and caring behaviors modelled by RN preceptors.* Paper presented at the Connecting conversations: Nursing Scholarship and Practice, Reykjavik, Iceland.

Pesut, B. (2002). The development of nursing students' spirituality and spiritual care-giving. *Nurse Education Today, 22*, 128-135.

Peters, R. S. (1970). Reason and Habit: The paradox of moral education. In Smith. P.G. (Ed.), *Theories of value and problems of education* (pp. 163-170). Chicago: University of Illinois Press.

Peterson, E. (2002). *THE MESSAGE: The Bible in Contemporary Language*. Colorado Springs: NavPress.

Porter, R. (1997). *The greatest benefit to mankind. A medical history of humanity from antiquity to the present*. London: Harper Collins Publishers.

Rafferty, A. M. (1996). Historical Research. In D. F. S. Cormack (Ed.), *The Research Process in Nursing* (Third edition ed., pp. 166-177). Oxford: Blackwell Science.

Ramsden, P. (1995). *Learning to Teach in Higher Education*. London: Routledge.

Raths, L., Harmin, M., & Simon, S. B. S. (1966). *Values and Teaching: working with values in the classroom*. Colombus: Charles E. Merrill Publishing Company.

Ravert, P., & Williams, M. (1997). The interpersonal competence instrument for nurses. *Western Journal for Nursing Research, 19*(6), p781, 711p.

Ray, M. A. (1989). The theory of bureaucratic caring for nursing practice in the organizational culture. *Nursing Administration Quarterly, 13*(2), 31-42.

Reason, P. (1994). Three approaches to Participative Inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of Qualitative Research* (pp. 324-339). Thousand Oaks: Sage Publications, Inc.

Reason, P. (1998). Three Approaches to Qualitative Inquiry. In N. K. Denzin & Y. S. Lincoln (Eds.), *Strategies of Qualitative Inquiry* (pp. 261-291). Thousand Oaks: SAGE Publications.

Reason, P., & Bradbury, H. (2001a). Introduction: Inquiry and Participation in Search of a World Worthy of Human Aspiration. In P. Reason & H. Bradbury (Eds.), *Handbook of Action Research* (pp. 1-14). London: SAGE Publications.

Reason, P., & Bradbury, H. (Eds.). (2001b). *Handbook of Action Research. Participative Inquiry and Practice*. London: SAGE Publications.

Reason, P., & Bradbury, H. (Eds.). (2001c). *Handbook of Action Research*. London: SAGE Publications.

Reid, J. C. (1994). *Nursing Education in Australian Universities-Report of the national review of nurse education in the higher education sector.1994 and beyond* (Government Report No. 0 644 35502 6). Canberra: Commonwealth of Australia.

Reynolds, W. J., Scott, B., & Jessiman, W. C. (1999). Empathy has not been measured in clients' terms or effectively taught: a review of the literature. *Journal of Advanced Nursing, 30*(5), 1177-1185.

Ries, E. (2003). The Art and Architecture of Caring. *PT magazine*, 36-43.

Roberts, K. L., & Taylor, B. J. (2002). *Nursing Research Processes: an Australian perspective* (2nd ed.). Melbourne: Nelson Thompson Learning.

Robertson, L. Y. (1989). *Careers in Nursing and Teaching*. Unpublished manuscript, Ballarat.

Rogers, C. (1967). *On Becoming a Person: A Therapist's view of Psychotherapy*. London: Constable and Company Ltd.

Rogers, C. R. (1980). *A way of Being*. Boston: Houghton Mifflin Company.

Rognstad, M.-K., Nortvedt, P., & Assland, O. (2004). Helping Motives in Late Modern Society: values and attitudes among nursing students. *Nursing Ethics, 11*(3), 227-239.

Rosner, L. (1997). The Growth of the Medical Education and the Medical Profession. In I. Loudon (Ed.), *Western Medicine - An Illustrated History* (pp. 147-159). Oxford: Oxford University Press.

Rushworth, L., & Happell, B. (2000). 'Psychiatric nursing was great, but I want to be a "real" nurse': Is psychiatric nursing a real choice for nursing students? *Australian and New Zealand Journal of Mental Health Nursing, 9*, 128-137.

Sadler, J. J. (2003). Who wants to be a nurse? motivation of the new generation. *Journal of Professional Nursing, 19*(3), 173-175.

Salovey, P., & Meyer, J. M. (1998). Emotional Intelligence. In J. J. Jenkins, K. Oatley & N. L. Stein (Eds.), *Human Emotions: a reader*. Oxford: Blackwell Publishers.

Saunders, J., & Retsas, A. (1998). Spirituality and nursing: toward an ontological understanding. *Collegian, 5*(1), 17-19.

Sax, S. (1984). *A strife of interests-Politics and policies in Australian health services*. Sydney: George Allen & Unwin.

Schmidt, L. A. (2003). Patients' perceptions of nursing care in the hospital setting. *Journal of Advanced Nursing, 44*(4), 393-399.

Scott Peck, M. (1988). *The Road Less Travelled - A new psychology of love, traditional values and spiritual growth* (Century Paperback Series ed.). London: Century Hutchinson Ltd.

Scott Peck, M. (1990). *The Different Drum* (Arrow edition 1990 ed.). London: Arrow books.

Scoufis, M. (2000). *Integrating the Graduate Attributes into the Undergraduate Curricula*. Sydney: University of Western Sydney.

Severinsson, E. I. (1998). Bridging The Gap Between Theory And Practice: A Supervision Programme For Nursing Students. *Journal of Advanced Nursing, 27*(6), 1269-1277.

Simmons, P. R., & Cavanaugh, S. H. (2000). Relationships among student and graduate caring ability and professional school climate. *Journal of Professional Nursing, 16*(2), 76-83.

Simons, J., & Robertson, E. (2002). Poor communication and knowledge deficits: obstacles to effective management of children's postoperative pain. *Journal of Advanced Nursing, 40*(1), 78-86.

Solomon, R., C., & Higgins, K. M. (1997). *A Passion for Wisdom - A Very Brief History of Philosophy*. New York: Oxford University Press.

Stember, M. L., & Hester, N. K. (1990). Research strategies for developing nursing as the science of human care. In Chaska. N.L. (Ed.), *The Nursing Profession: turning points.* (pp. 165-173). St. Louis: C.V. Mosby Company.

Summers, A. (1997). Nurses and Ancillaries in the Christian Era. In I. Loudon (Ed.), *Western Medicine-an illustrated history* (pp. 192-206). New York: Oxford University Press.

Tansey, E. M. (1997). From the Germ Theory to 1945. In I. Loudon (Ed.), *The Oxford Illustrated History of Western Medicine* (pp. 102-122). Oxford: Oxford University Press.

Taylor, B. J. (1994). *Being Human. Ordinariness in nursing.* Melbourne: Churchill Livingstone.

Taylor, J. C. (1999). *Novex Analysis: A cognitive science approach to Instructional Design*, from http://www.usq.edu.au/material/unit/resource/taylor/novex.htm

Taylor, J. S. (1997). Nursing ideology: identification and legitimation. *Journal of Advanced Nursing, 25*(3), 442-446.

Templeton, J. (1969). *The evolution of a Melbourne Hospital-1869-1969.* Melbourne: Robertson & Mullens Pty Ltd.

Toohey, S. (1999). *Designing Courses for Higher Education*. Buckingham: Open University Press.

Travelbee, J. (1977). *Interpersonal aspects of nursing* (2nd ed.). Philadelphia: F.A. Davies Company.

Trohler, U., & Prull, C. (1997). The Rise of the Modern Hospital. In I. Loudon (Ed.), *Western Medicine An illustrated history* (pp. 160-175). Oxford: Oxford University Press.

Tutton, E., & Seers, K. (2003). An exploration of the concept of comfort. *Journal of Clinical Nursing, 12,* 689-696.

Ulrich, T., & Cay-Rudiger, P. (1997). The Rise of the Modern Hospital. In I. Loudon (Ed.), *Western Medicine - an illustrated history* (pp. 160-175). Oxford: Oxford University Press.

Valentine, K. (1988). Caring is More than Kindness: Modelling Its Complexities. *Journal of Nursing Administration, 19*(11), 28-36.

Washington, G. T. (2001). Family advocates: caring for families in crisis. *Dimensions of Critical Care Nursing, 20*(1), 36-40.

Watson, J. (1985). *Nursing. The philosophy and science of caring*. Boulder: Colorado Associated University Press.

Watson, J. (1989a). A new paradigm of curriculum development. In E. O. Bevis & J. Watson (Eds.), *Toward a caring curriculum: a new pedagogy for nursing* (pp. 37-50). New York: National League for Nursing.

Watson, J. (1989b). Trans formative thinking and a caring curriculum. In E. O. Bevis & J. Watson (Eds.), *Toward a caring curriculum: a new pedagogy for nurses.* (pp. 51-61). New York: National League for Nursing.

Watson, J. (1990). Preface. In M. Leininger & J. Watson (Eds.), *The Caring Imperative in Education* (pp. xiii-xiv). New York: National League for Nursing.

Watson, J. (1998). *Nursing. Human science and human care: a theory of nursing*. New York: National League of Nursing.

Watson, J. (1999). *Post modern nursing and beyond*. London: Churchill Livingstone.

Watson, J. (2000a). *Centre for Human Caring-Mission and Goals*. Retrieved 16/11/2000, 2000, from http://freenet.uchsc.edu/son/clinic/watsonfinal/goals.htm

Watson, J. (2000b). *Theory of Human Caring*. Retrieved 16/11/00, 2000, from http://freenet.uchsc.edu/son/clinic/watsonfinal/wct.htm

Watson, J. (2002). Intentionality and caring-healing consciousness: a practice of transpersonal nursing. *Holistic Nursing Practice, 16*(4), 12.

Watson, J. (2003). Love and Caring: Ethics of Face and Hand - An Invitation to Return to the Heart and Soul of Nursing and our Deep Humanity. *Nurse Administration Quarterly, 27*(3), 197-202.

Watson, J. (2005). *Caring Science as Sacred Science*. Philadelphia: F.A.DAVIS Company.

Watson, J., & Foster, R. (2003). The *Attending Nurse Caring Model**: integrating theory, evidence and advanced caring-healing therapeutics for transforming professional practice. *Journal of Clinical Nursing, 12*, 360-365.

Watson, J., & Smith, M. C. (2002). Caring science and the science of unitary human beings: a trans-theoretical discourse for nursing knowledge development. *Journal of Advanced Nursing, 37*(5), 452-461.

Watson, M. J. (1996). Watson's Theory Of Transpersonal Caring In: Blueprint For Use Of Nursing Models: Education, Research, Practice And Administration. *NLN Publ, 14*(2696), 141-184.

Webb, C. (1998). Caring, curing, coping: Toward an Integrated Model. In E. C. Hein (Ed.), *Contemporary Leadership in Nursing* (5th ed., pp. 3-15). Philadelphia: Lippincott.

While, A. (1998). Reflections on nursing as a career choice. *Journal of Nursing Management, 6*, 231-237.

Wickett, D., McCutcheon, H., & Long, L. (2003). The nursing shortage in the United States of America: an integrative review of the literature. *Journal of Advanced Nursing, 43*(4), 335-350.

Widmark-Petersson, V., Von Essen, L., & Sjoden, P. (1998). Perceptions Of Caring: Patients And Staff's Associations To Care-Q Behaviours. *Journal of Psychosocial-Oncology (J-Psychosoc-Oncol), 16*(1), 75-96.

Wiles, V. H. (1975). The practice of nursing-Clinical Specialisation. *The Australian Nurses' Journal1, 5*(3), 6-9.

Wilkes, L., & Wallis, M. (1993). The five Cs of caring: the lived experiences of student nurses. *The Australian Journal of Advanced Nursing, 11*(1), 19-25.

Wilkes, L. M., & Wallis, M. C. (1998). A model of professional nurse caring: nursing students experience. *Journal of Advanced Nursing, 27*(3), 582-589.

Wilson, G. (2004). Report from National Clinical Forum. In L. Y. Robertson (Ed.). Toowoomba.

Wilson, M. (2004). Reconsidering Autonomy. *Connections. Royal College of Nursing, Australia Newsletter, 7*(2), 13.

Wood, R., & Tolley, H. (2003). *Test Your Emotional Intelligence*. London: Kogan Page Ltd.

Woodward, V. M. (1997). Professional caring: a contradiction in terms? *Journal of Advanced Nursing, 26*, 999-1004.

Woodward, W. (2003). Preparing a New Workforce. *Nursing Administration Quarterly, 27*(3), 215-222.

Wright, L. M., & Leahey, M. (2000). *Nurses and Families A Guide to Family Assessment and Intervention* (third edition ed.). Philadelphia: F.A. Davis Company.

Wright, S., & Sayre-Adams, J. (2000). *Sacred Space - Right Relationships and Spirituality in Healthcare*. London: Churchill Livingstone.

Wynne, M., & Armstrong, W. (2003). Building on Values: The future of Health Care in Canada. *Health Issues, 74*(March), 9-12.

Selected Bibliography

Aiken, L., & Fagin, C. (1992). *Charting Nursing's Future - Agenda for the 1990's* (First ed.). Philadelphia. J.B Lippincott Company.

Allmark, P. (1995). Can there be an ethics of care. *Journal of Medical Ethics, 21*(1), p 19

Allmark, P. (1996). Reply to Ann Bradshaw. *Journal of Medical Ethics, 22*(1), p13

American Nurses' Association. (1985). *Code for nurses-with interpretive statements*. Kansas City: American Nurses' Association.

Arnold, E. (1997). Caring From The Graduate Student Perspective. *International Journal For Human Caring, 1*(3 (Fall)), 32-42.

Astedt-Kurki, P., & Liukkonen, A. (1994). Humour in nursing care. *Journal of Advanced Nursing, 20*, 183-188.

Australia Nursing Council Inc. (1995). *Code of Professional Conduct for Nurses in Australia*. Canberra: Australian Nursing Council Inc.

Barnard, A., & Sandelowski, M. (2001). Technology and humane nursing care: (ir)reconcilable or invented difference. *Journal of Advanced Nursing, 34*(3), 367-375.

Barnes, D. M., Craig, K. K., & Chambers, K. B. (2000). A review of the concept of culture in holistic nursing literature. *Journal of Holistic Nursing, 18*(3), p207-215p.

Barnhart, C. L., & Barnhart, R., K, (Eds.). (1979). *The World Book Dictionary*. Chicago: Doubleday & Company.

Barnhart, R. K. (1988). *The Barnhart dictionary of etymology*. USA: The H. W. Wilson Company.

Bates, E., & Linder-Pelz, S. (1987). *Health Care Issues*. Sydney: Allen & Unwin.

Bauer, J. A. (1990). Caring as the central focus in nursing curriculum development. In M. Leininger & J. Watson (Eds.), *The caring imperative in education.* (pp. 255-266). New York: National League for Nursing.

Bechtel, G. A. (1999). Future Realities In Nursing: Partnerships, Practice And Economics. *Nursing Connections, 12*(1 (Spring)), 19-26.

Beletz, E. E. (1990). The "Red Herrings" of the entry issue. In Chaska. N.L. (Ed.), *The Nursing Profession- Turning Points* (pp. 61-68). St. Louis: C.V. Mosby Company.

Bernhard, L. A., & Walsh, M. (1990). *Leadership: the key to the professionalization of nursing*. St. Louis: C.V. Mosby.

Bigger, S. (1999). Spiritual, moral, social and cultural education. In Bigger, S. & Brown, E. (Eds.), *Spiritual, moral, social and cultural education- exploring Values in the curriculum* (pp. 3-16). London: David Fulton Publishers.

Bishop, A. H., & R., S. J. (1999). A Philosophical Interpretation Of Nursing. *Scholarly Inquiry For Nursing Practice, 13*(1 (Spring)), 17-27.

Blegen, M. A., & Tripp-Reimer, T. (1997). Nursing theory, nursing research, and nursing practice: Connected or separate? In J. C. McCloskey & H. Grace, K. (Eds.), *Current Issues in Nursing* (Fifth Edition ed., pp. 68-74). St Louis: Mosby.

Bloch, D. (1985). A conceptualization of nursing research and nursing science. In J. C. McCloskey & H. K. Grace (Eds.), *Current Issues in Nursing* (2nd Edition ed., pp. 124-138). Boston: Blackwell Scientific Publications.

Bolton, S. (2000). Who cares? Offering emotion work as a 'gift' in the nursing labour process. *Journal of Advanced Nursing, 32*(3), 580-586.

Bonhoeffer, D. (1978). *Ethics* (Smith. N.H, Trans.). London: SCM Press Ltd.

Bowden, P. L. (1995). The ethics of nursing care and 'the ethic of care'. *Nursing Inquiry, 2*, 10-21.

Boyer, E. L., & Levine, A. (1981). *A Quest For Common Learning* (Second ed.). Washington, D.C: The Carnegie Foundation.

Boyle, E. D. (1994). The use of dance/movement therapy in psychosocial nursing. In P. L. Chinn & J. Watson (Eds.), *Art and aesthetics in nursing* (pp. 301-316). New York: National League for Nursing Press.

Bradshaw, A. (1996). Yes! There is an ethic of care: a reply for Peter Allmark. *Journal of Medical Ethics, 22*(1), p 8.

Breunig, K. (1994). The art of painting meets the art of nursing. In P. L. Chinn & J. Watson (Eds.), *Art and Aesthetics in Nursing* (pp. 191-202). New York: National League for Nursing Press.

Caldwell-Gwin, J. A., Carr, L. A., Harmon, B. R., Jarlsberg, C. R., McCormick, J., & Noone, K. W. (1989). Modeling and Role-Modeling. In M.-T. A (Ed.), *Nursing Theorists and their Work* (Second ed., pp. 264-276). St Louis: C.V. Mosby Company.

Cameron-Traub, E. (1995). Clinical, conceptual and empirical aspects of nursing practice. In G. Gray & R. Pratt (Eds.), *Scholarship in the discipline of nursing* (pp. 1-20). Melbourne: Churchill Livingstone.

Campbell, J. (1988). Inside lives: the Quality of Biography. In Sherman, R.R. & Webb, R.B. (Eds.), *Qualitative research in education: Focus and Methods* (pp. 59-75). London: The Falmer Press.

Cara, C. M. (1999). Relational Caring Inquiry: Nurses' Perspective On How Management Can Promote A Caring Practice. *International Journal For Human Caring (Int-J-Hum-Caring) 3 (1)*(Spring 1999), 22 - 30.

Carter, M. (2002). The State of Private Insurance in Australia. *Health Issues* (73), 7-9.

Cellar, H. C., Lovell, N. H., & Chan, D. K. Y. (1999). The potential impact of homecare on clinical practice. *Medical Journal Australia, 171*(November), 518-521.

Chadwick, G. L. (2001). Clinical trials in the 21st Century: a Global Approach. *Research in Nursing & Health, 24*, 541-542.

Clare, J., & van Loon, A. (2003). Best practice principles for the transition from student to registered nurse. *Collegian, 10*(4), 25-31.

Clarke, J. (1998). The international classification for nursing practice project. *Online Journal of Issues in Nursing* (September 30), 7pages.

Condon, E. (1986). Theory derivation: Application to nursing. *Journal of Nursing Education, 25*(4), 156-159.

Cormack, D. F. S. (Ed.). (1996). *The Research Process in Nursing*. Oxford: Blackwell Science.

Coulon, L., Mok, M., Krause, K., & Anderson, M. (1996). The Pursuit Of Excellence In Nursing Care: What Does It Mean? *Journal of Advanced Nursing, 24*(4 (Oct)), 817-826.

Creswell, J. W. (2002). *Educational research: Planning, Conducting, and Evaluating Qualitative and Qualitative Research*. Upper Saddle River: Merrill Prentice Hall.

Cronin, S. N., & Harrison, B. (2000). Caring Behaviors Assessment: Cronin to Janet Rankin.

Crotty, M. (1998). *The foundations of social research: meaning and perspective in the research process*. St Leonards: Allen & Unwin.

Curran, C. R. (1999). Caring from the heart...and the head. *Nursing Economics$, 17*(2), p73.

Curran, C. R. (1999). Preparing tomorrow's nurses for the no margin-no mission world of health care. *Nursing Economics$, 17*(4), p193.

Dahlberg, K. (1994). The Collision Between Caring Theory And Caring In Practice As A Collision Between Feminine And Masculine Cognitive Style. *Journal Of Holistic Nursing, 12*(4 (Dec), 391-401.

Darbyshire, P. (1992). The core of nursing. *Nursing Times, 88*(36), 44.

Darbyshire, P. (1993). Preserving nurse caring in a destitute time. *Journal of Advanced Nursing, 18*, 507-508.

Dawson, K., P. (1992). Attitude and assessment in nurse education. *Journal of Advanced Nursing, 17*, 473-479.

DeLaune, S. C., & Ladner, P. K. (Eds.). (1998). *Fundamentals of nursing: standards and practice*. New York: Delmar Publishers.

Denzin, N. K., & Lincoln, Y. S. (Eds.). (1994). *Handbook of Qualitative Research.* Thousand Oaks: SAGE Publications.

Denzin, N. K., & Lincoln, Y. S. (2000). *Handbook of Qualitative Research* (2nd ed. ed.). Thousand Oaks: Sage Publications, Inc.

Devine, E. C. (1990). Meta-analysis: a new approach for reviewing research. In Chaska, N.L. (Ed.), *The Nursing Profession: turning points.* (pp. 180-185). St. Louis: C.V. Mosby Company.

Dickoff, J., James, P., & Wiedenbach, E. (1968). Theory in a Practice Discipline. *Nursing Research, 17*(5), 415-435.

Dolan, B., & Walsh, M. (1999). Emergency Nurses and Their Perceptions Of Caring. *Emergency Nurse (Emerg-Nurse) 1999, July – Aug,* 7(4), 24 -31.

Downie, E. S., & Telfer, E. (1980). *Caring and curing. A philosophy of medicine and social work*. London: Methuen.

Dyson, J. (1998). Nurses' conceptualizations of caring attitudes and behaviors. In E. C. Hein (Ed.), *Contemporary leadership behavior - selected readings* (5th ed., pp. 16-25). Philadelphia: Lippincott.

Dyson, J., Cobb, M., & Forman, D. (1997). The meaning of spirituality: a literature review. *Journal of Advanced Nursing, 26*, 1183-1188.

Eben, J. E., Gashti, N. N., Nation, M. J., Marriner-Tomey, A., & Nordmeyer, S. B. (1989). Dorethea E. Orem Self-Care Deficit Theory of Nursing. In A. Marriner-Tomey (Ed.), *Nursing Theorists and Their Work* (Second ed., pp. 118-132). St Louis: C.V. Mosby Company.

Eisner, E. W. (1991). *The Enlightened Eye*. New York: Macmillan Publishing Company.

Elias, J. L. (1990). Teaching as cure and care: a therapeutic metaphor. *Religious Education, 85*(3), p436 439p.

Emden, C. (1991). Ways of knowing in nursing. In G. Gray & R. Pratt (Eds.), *Towards a Discipline of Nursing* (pp. 11-30). Melbourne.

Emden, C. (1997). A conversation with Margarete Sandelowski and Philip Darbyshire: issues in qualitative enquiry. *Nursing Inquiry, 4*, 138-141.

Fagermoen, M. S. (1997). Professional Identity: Values Embedded In Meaningful Nursing Practice. *Journal Of Advanced Nursing, 25*(3), 434-441.

Fagerstrom, L. (1998). Measuring the unmeasurable: a caring science perspective on patient classification. *Journal of Nursing Management, 6*, 165-172.

Fletcher, J. (1997). Do Nurses Really Care? An Agenda For Higher Education Following Recent Mergers. *Journal of Nursing Management, 5*(2), 97-104.

Fogg, L., & Gross, D. (2000). Threats to validity in Randomised Control Trials. *Research in Nursing & Health, 23*, 79-87.

Frost, P. J. (1999). Why compassion counts! *Journal of Management Inquiry, 8*(2), p127.

Giordano, B. P. (1993). We need to question health care's sacred cows, fatted calves. *AORN Journal, 58*(September), 460-461.

Hall, B. A., & Allan, J. D. (1994). Self in Relation: A Prolegomenon for Holistic Nursing. *Nursing Outlook, 42*(3), 110-116.

Halloran, E. J. (Ed.). (1995). *A Virginia Henderson Reader-Excellence in Nursing*. New York: Springer Publishing Company.

Hellwig, S. D., & Ferrante, S. (1993). Martha Rogers' Model in Associate Degree Education. *Nurse Educator, 18*(5), 25-27.

Henderson, V. (1979). *Basic Principles of Nursing Care*. Geneva: International Council of Nurses.

Henderson, V., & Nite, G. (1978). *Principles and Practice of Nursing* (Sixth Edition ed.). New York: Macmillan Publishing Company.

Hughes, L. C. (1998). Development Of An Instrument To Measure Caring Peer Group Interactions. *Journal of Nursing Education, 37*(5 (May)), 202-207.

Hughes, L. C., Kosowski, M. M., Grams, K., & Wilson, C. (1998). Caring Interactions Among Nursing Students: A Descriptive Comparison Of 2 Associate Degree Nursing Programs. *Nursing Outlook, 46*(4 (Jul-Aug)), 176-181.

Ingall, A. H. (2001). Professional nurse caring - a review of the literature. *St Vincent's Health Care Campus Nursing Monograph*, 5-9.

Kozier, B., Erb, G., Blais, K., & Wilkinson, J. M. (1995). *Fundamentals of Nursing, Concepts, Process, and Practice* (5th ed.). Redwood City: Addison-Wesley.

Kozier, B., Erb, G., & Bufalino, P. M. (1989). *Introduction to Nursing*. Redwood City: Addison-Wesley.

Kozier, B., Erb, G., & Olivieri, R. (1991). *Fundamentals of Nursing. Concepts Process and Practice* (4th ed.). Redwood City: Addison Wesley Publishing Company.

Lacey, R. (1997). "Have a heart" - Exploring the experience of cardiac bypass surgery. *ACORN Journal, Summer*, 21-25.

Lawrence, o. t. R., Brother. (1999). *The Practice of the Presence of God.* Nashville: Thomas Nelson Publishers.

Leininger, M., & Watson, J. (Eds.). (1990). *The Caring Imperative in Education.* New York: National League for Nursing.

Lumby, J. (1991). Threads of an emerging discipline: praxis, reflection, rhetoric and research. In G. Gray & R. Pratt (Eds.), *Towards a Discipline of Nursing* (pp. 461-483). Melbourne: Churchill Livingstone.

MacDougall, G. (1997). Caring-a masculine perspective. *Journal of Advanced Nursing, 25*, 809-813.

Mackenzie, G., M. (1997). The caring doctor is an oxymoron. *British Medical Journal, 315*, 687-688.

McCormick, K. A., & C.B., J. (30.9.1998). *Is one taxonomy needed for health care vocabularies and classifications?* Retrieved 5.10.98, 2000, from http:www.nursingworld.org/ojin/tpc7/tpc7/-2.htm

McKenna, G. (1993). Caring is the essence of nursing practice. *British Journal of Nursing, 2*(1), 72-76.

National League For Nursing (1999). *A Vision for Nursing Education*. New York: National League for Nursing.

Nolan, P. W., Brown, B., & Crawford, P. (1998). Fruits without labour: the implications of Friedrich Nietzsche's ideas for the caring professions. *Journal of Advanced Nursing, 28*(2), 251-259.

Nortvedt, P. (2001). Needs, closeness and responsibilities. An inquiry into some rival moral considerations in nursing care. *Nursing Philosophy, 2*, 112-121.

Phillips, P. (1993). A deconstruction of caring. *Journal of Advanced Nursing, 18*, 1554-1558.

Potter, P. A. (2001). Nursing Healing and Caring. In J. Crisp & C. Taylor (Eds.), *Potter and Perry's fundamentals of nursing* (pp. 103-113). Sydney: Mosby.

Ray, M. A. (1987). Technological Caring: A New Model in Critical Care. *Applied Research, 4*(3), 166-173.

Rowe, J., & Davison, L. (2002). Exploring nursing: A conversation about domiciliary nursing. *Collegian, 9*(3).

Saltman, D. (1998). The 'Disease model' challenged. In P. Baume (Ed.), *The Tasks of Medicine- An Ideology of Care* (pp. 221-237). Sydney: MacLennan + Petty.

Sarter, B. J. (1990). Philosophical Foundations of Nursing Theory: a discipline emerges. In N. L. Chaska (Ed.), *The Nursing Profession - Turning Points* (pp. 223-229). St Louis: C.V. Mosby Company.

Sellars, E. T. (2000). Revitalise to survive. *Collegian, 7*(1), 17-22.

Sergiovanni, T. (1992). On Rethinking Leadership: A Conversation with Tom Sergiovanni. *Educational Leadership*, 46-49.

Shotton, L., & Seedhouse, D. (1998). Practical Dignity in Caring. *Nursing Ethics, 5*(3), 246-255.

Sorenson, K. C., & Luckman, J. (1986). *Basic Nursing- A Psychophysiologic Approach* (2nd ed.). Philadelphia: W.B. Saunders Company.

van Hooft, S. (1996). Bioethics and caring. *Journal of Medical Ethics, 22*(2), p83, 87pages.

Widmark-Petersson, V., Von-Essen, L., Lindman, E., & Sjoeden, P.-O. (1996). Cancer Patient And Staff Perceptions Of Caring Vs Clinical Care. *Scandinavian Journal of Caring Sciences, 10*(4), 227-233.

Wolf, Z. R., Giardino, E. R., Osborne, P. A., & Ambrose, M. S. (1994). Dimensions Of Nurse Caring. *Image: Journal of Nursing Scholarships, 26*(2 (Summer)), 107-111.

APPENDIX 1

Phase I: Letters to the GRN Participants

APPENDIX 2

Phase II: Information Package to the Expert Group

Professional Personalised Car*: a theoretical framework for teaching caring in nursing

Introduction

The development of this framework for teaching caring in nursing emerged as a combination of several factors. These arose from this research and concepts taken from the literature of nursing caring, psychology and philosophy. **Professional Personalised Car*** (PPCar*) is a framework in which the undergraduate student in nursing is taught the caring concepts. This is done within a framework beginning to act/nurse in a **Professional** manner, active listening and discernment to ensure that patient care is **Personalised.** A caring attitude is fostered in students so that they are potentially able to deliver nursing care that is caring - **Car*.** The students' growth is towards an understanding of nursing caring, professionalism and an ability to focus on the patient and then through discernment to meet the patients personal needs.

Both the practicalities of learning professional behaviour and the basic premises of the nursing profession are fundamental to the ongoing development of the undergraduate student. In addition to the ability to act professionally a primary caring skill is to be able to listen to the patient. The word 'listening' was considered to be insufficient to really describe what this particular caring enactment meant the ability to 'hear' what the patient was saying/meaning. The term, discernment, will be used to describe/convey the complexity of this multi-layered skill. It is a higher order skill incorporating a sensitivity to empathise, a knowledge base to intelligently make sound professional judgements regarding nursing care and the wisdom to be able to differentiate between the needs and the wants of patients in order for caring to be perceived/experienced by the patient. Through the use of discernment the patients unique concerns/needs/cares are met in order to give **Personalised** care. Although there was a core of caring enactments in this research, it was found that caring was in essence part of the caring nature of the RN and the delivery of caring patient care was a combination of professionally acquired skills and an inherited caring nature.

I argue that although the caring enactments could be taught, and it must be noted that some of these skills are taught anyway, a caring nature/attitude, is something that cannot be taught – only fostered.

Rationale for the development of the theoretical framework

The concept of a vocationally inspired caring nurse is no longer valid. Nursing, recently recognised as a profession needs to ensure that its future RN are able to act professionally and still care. The 'mix' of students entering nursing in Queensland and the lack of a framework to teach caring that is applicable to Australian nurse education were additional factors that further indicated the need for a framework. These two factors will be briefly discussed prior to giving an outline of the proposed PPCar* framework.

The undergraduate student 'mix'

There are two factors that need to be considered in the current student 'mix'. The first is that all students in nursing programs do not necessarily want to nurse and the second is the wide range of academic ability in student cohorts.

In the early years of the transfer of nurse education to the tertiary sector, entry was decided on academic merit as well as interviews to determine the 'suitability' of applicants. Interviews were conducted on all prospective students until as recently as 1983/4 and the university at which I am at the moment interviewed mature age students through to 1993. All nursing programs in Queensland use a computerised admission system to select students. Nursing departments believe that this is important as it fits in with the entry system of all other university programs. While this is not problematic in terms of equity in admission procedures there are students who enter nursing simply to get into a university program or the probability of gaining permanent employment. These students often have no real desire to nurse and there is the potential for them become uncaring RNs. These students need to be taught basic 'caring' skills.

The inherently caring students entering nursing programs would be given the tools to enhance their innate caring abilities so that the care that they give is firstly professional and secondly enables them to give that care with out suffering stress and burnout in the current climate of health care environment.

A further factor is the academic background of the students. The mix is considerable and likely to remain so. A generous sprinkling of mature-age students of 35+ who left school in Year 9 and have not studied since, except to complete a semester of part-time 'preparation to study' course. The preparation is not always adequate. At the other end of the scale is the exceptional 17 year old who has completed high school with an academic record of high distinction and has always wanted to nurse. The majority fall in-between; on average two-thirds of the entrants have 'run of the mill' school-leaving scores. This scenario obviously varies from university to university but comparing the student entry levels in 2004 this scenario is typical. The complex caring theories of nursing generated in the USA are not particularly suited to this 'mix' of sometimes academically challenged students. Nursing students in the USA complete a four-year nursing degree and must successfully complete the first year of an arts degree prior to entry to the nursing major stream.

Structuring/teaching caring in the Australian context

Fostering caring on campus in individual students is difficult in many Australian universities. In many of the nursing programs the intakes of 200 or more students (a total of 600+ students in a single program) make for individual caring of students difficult. Getting to know the students and the fostering of any innate caring ability is difficult and often left to the clinical facilitators, with small groups of six to eight students, who are committed to caring concepts in nursing.
The inclusion of caring in undergraduate programs varies. Caring is either included formally in a course/unit devoted to theories of caring and/or the philosophical underpinnings of the curriculum are caring focussed and the lecturers include the caring focus in lectures and large tutorial groups.

Philosophical underpinnings of the theory

The framework is intended to be an intensely practical framework underpinned by two philosophies. The first keystone is the concept of 'being', initially articulated by Watson in 1985 prior to the development of the Intentional Transpersonal Caring-Healing Theory. Watson in explicating this theory discusses the noetic aspects of caring, intentionality and transpersonal caring, being "perhaps the deepest view of nursing" (4). While the Intentional Transpersonal Caring-Healing theory of nursing is too advanced for many Australian students Watsons early work of being is one that is understandable and teachable. Although Watson does not specifically use the concept of being professional in caring the thought is inherent in her writing. Watsons philosophy of being, (the early work) is a concept that is easy to grasp that will lead the neophyte student through the practicalities of being and becoming a professional RN. (it is here that the tender loving care is articulated)

Watson does not indicate how the Being is enacted, choosing in her later work to focus on the characteristics of the nurse and not the patient. Suggestions such as being focussed, meditation and cultivating intentionality are aspects of learning to be in a caring mode, and are not suitable for the beginning student to assimilate.

The second philosophical keystone is Mayeroffs position on caring being the 'growth of the other'. Mayeroffs eight ingredients of caring are essentially bound up in the notion of the 'tough love' that is experienced by parents as they seek in love to lead their child through adolescence to adulthood.

Concepts from Campbell notions of moderated love in the nursing profession [Campbell, 1984 #212], maintaining soft boundaries [Scott Peck, 1988 #595; Scott Peck, 1990 #594], unconditional positive regard (UPR) from the noted psychologist Karl Rogers [Rogers, 1967 #532; Rogers, 1980 #384] and theories from philosophers such as Nouwen and Lewis [Lewis, 1998 #525][Nouwen, 1979 #434; Nouwen, 1989 #531; Nouwen, 1992 #196] and nursing theorist Leininger are also included.

Professional Personalised Car* Objectives structure and process

The nursing profession in Australia has codes of practice and exit competency statements that nursing students must be aware of and be competent in. These codes and competencies are generic and imply caring.

I argue that the student need not have a 'vocation' to nurse or have an innate caring nature in order to give professional 'caring' care. The current climate of health care necessitates a professional who is able to tune into the patients needs (not wants) so that in essence the patient (in their ego-centric illness state) is most likely to perceive the care as being caring whether the nurse is inherently caring or not.

Objectives

The primary objective of the PPCar* framework is to facilitate the conceptualisation of the value of professional caring. The notion of the conceptualisation of values is a fourth level educational objective in the affective domain as defined by Krathwohl et al. [Krathwohl, 1964 #161] All students are not expected to reach the final level of internalisation of the value complex of caring.

The PPCar* framework covers three concepts, Professional Care, Personalisation of Care and Transpersonal Caring with a subsidiary (to the overall primary objective) primary objective for each concept.

The secondary objectives of the PPCar* framework are

- Facilitate the development of professional attitudes and behaviours.
- A commitment by students to enhance their self-knowledge.
- Willingness to learn to listen and discern
- Develop a beginning understanding of caring theories
- Understand the meaning of personal caring care

Structure

These three areas can be conceived of as being three modules.
Module I The foundations of a professional identity at a beginning level will be taught together with an expectation of the student behaving in a professional manner.
Module II The focus is on how students can be taught/learn the fundamental principles of 'being' involves teaching self-knowledge through the two elements of social and emotional competence. The need to learn communication is addressed - listening and discerning the patient's unique needs. Attitudes of unconditional acceptance of the patient will also be taught and fostered.
Module III Theoretical aspects of caring. Philosophy of caring and theories of caring.

Modules of Professional Personalised Car*

Modules	Focus and Content	Concepts 'from'
Module I Professional Care	**Assimilation of the essentials of the nursing profession** • Codes of conduct, ethics • ANCI competencies • Reflective practice	**Campbell** **Peck**
Module II Personalising Care	**Developing the skills and attitudes:** • Listening • Unconditional positive regard • Discernment • Emotional Competence	**'Data'** **Watson** **Rogers** **Goleman**
Module III Transpersonal Caring	**Theoretical aspects of caring** • Introduction to the philosophy of caring • Caring in nursing theories	**Mayeroff** **Nouwen and Lewis** **Watson**

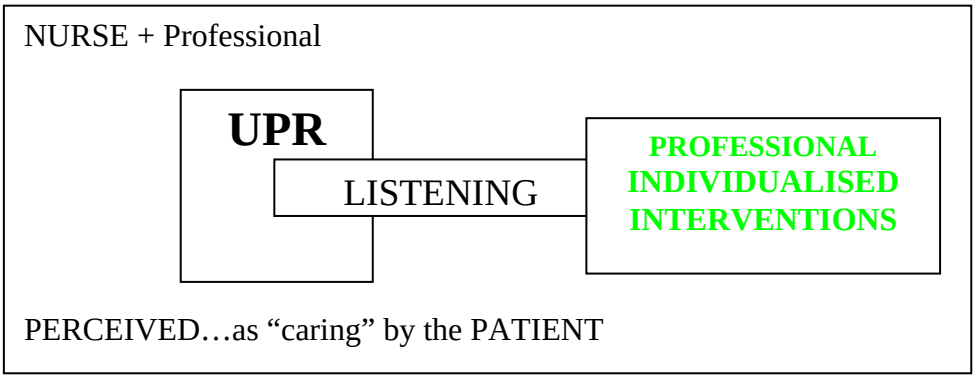
The caring behaviours of students exiting will be chiefly addressed during the students' clinical experience. This will need to be incorporated into the Clinical Assessment Tool. The clinical assessment often includes students reflections and PPCar* lends itself to the use of reflecting on caring incidents. It is unrealistic to expect all to exit on

the same level and also unrealistic to expect all students to exit on either Level Level II or I. There will be students who do not reach the first level but will have the necessary background to be able to reflect on their practice and continue to grow and develop caring attitudes.

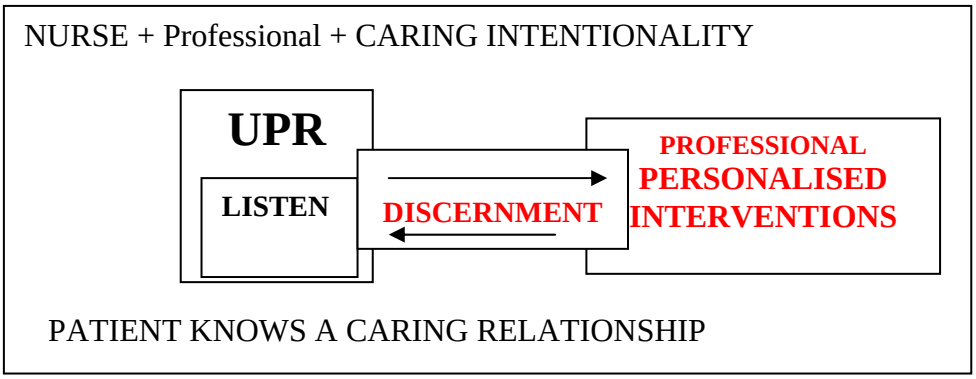
A further premise of these two processes is that the RN will be able to move from the second level to the first when personal factors arise and they are not able to fully operationalise their caring with intentionality. There is also the possibility that in nursing speciality areas such as palliative care the RN who normally operates on Level I will be able to move to Level II.

Process

LEVEL I - Mapping the process of individualised patient care



LEVEL II - Mapping the process of personalised patient care



Discussion of the Content of PPCar* Modules

Module I – Professional Care

This module is an introduction to the concepts of a profession from a practical aspect. The need for and what professional behaviour is, is often a foreign concept to students. Statistics however show that the last 10 years have seen large cohorts of students entering university who are the first members of the family to have a higher education. The understanding of what a 'profession' is on an elementary level and how to behave in a professional capacity is a topic that has not received much attention in the attention of nursing lecturers. The Australian Nursing Council (ANC) competencies and the importance of Reflective practice need to be introduced at an early stage of the undergraduate program. The introduction of the ANC Codes of conduct and ethics as parameters of practice need not be given in detail but it is considered important that students are introduced to these concepts at an early stage of the program.

Module II – Personalising Care

The student is introduced to the concept of emotional and social competence and with the help of a guide is able to apply the concepts to their own behaviours. The link between the concepts of professionalism and intentionality are brought together in self-knowledge and a beginning ability to focus on the patient so the patient perceives that the care that is being given is caring. Unconditional positive regard and listening are twin skills that are fundamental to the art of being able to either discern or be aware of the patients' needs. It is at this stage that the two levels of Car* are most apparent.

Module III – Transpersonal Caring

The introductions to philosophical and nursing theories on caring are shaped/created to suit the needs of the cohort of students. This will be done differently in different universities and in different intakes in the same university. The intention here is to use the assessment to challenge students on an individual level.

CURRICULUM

Design

- Incorporate the PPCar* as a theoretical framework.[5] as an organizational structure for the ANCI Competencies

Structure

- Course/modules on PPC* to be offered as per second column

COURSE/UNIT

Options for offering the PPC*

- ✓ Module- once every year. [1]
- ✓ Core (compulsory) course, taken either after the first clinical experience[2] or in the third year, second semester[3].
- ✓ The faculty members actively introduce the concepts into each clinical unit/course.[4]

[5] Standard requirements by the Queensland Nursing Council are that a theoretical framework is used to underpin all Pre-registration curricula.

[1] This would be incorporated into a particular clinical unit/course that leads into clinical practicum. Scaffolding learning is essential in teaching values.

[2] Students find it difficult to incorporate such advanced notions prior to going into clinical practicum.

[3] In this case the faculty would assign such a course to a experienced lecturer who the students already have had and is considered a good role model.

[4] There are inherent problems in this situation as lecturers often consider their material too important to have to introduce further material into their unit.

Conclusion

Although the framework contains fundamental elements that are included in all undergraduate nursing programs the uniqueness of the PPCar* framework is that it has taken these elements and incorporated them into a single framework to generate professional individualised/personalised caring for all patients.

The creativity and style of the individual lecturer will enable the PPCar* to be interpreted as a course that reflects the individuality and the academic freedom of the lecturer. However the importance of the role model of the individual at the subliminal level cannot be excluded and it will be up to the Head of Department or faculty to ensure that a suitable lecturer is given the responsibility of implementing the PPCar*.

The professional aspects of the nursing profession, assessments of patients nursing needs psychosocial and physical are all dealt with in diverse and separate course/unit in most nursing curricula. While this may seem to be a generalisation and a criticism of the undergraduate programs it reflects what often happens in the bigger nursing programs in Australia. This compartmentalising of knowledge is detrimental to the overall generation of professional caring care essential to the patient and the image of the nursing profession.

The cultivation of a professional mind-set /stance is one that will need to be fostered in the overall program. The balance of role modelling caring and the implementation of a quality program that reflects the profession and all that the profession professes to be is a task that necessitates an overall commitment from the faculty. The future RN present student cannot be expected to come already equipped to practice such care and therefore a framework should be in place in order to prepare the student to practice PPCar* giving all patients professional individual or personalised caring care.

APPENDIX 3

Clinical Evaluation Tools
St Luke's Hospital circa 1954

APPENDIX 4

A GRN Reflection

RN 15-R1 (CITY)

Dear Lorna,

I have just completed my first week in a post graduate position in a medical/surgical ward and list below incidences of caring I have noted during this time.

· A good knowledge base and a willingness to use it demonstrated to me a genuine concern for the patient. For example, a patient who complained of a sore hip after a fall in the hospital was immediately cared for by the nurse I worked with as if a fracture was present, although x-rays had not yet confirmed a fracture. The nurse not only continued to check the patient's status but initiated pain relief when required and only turned the patient using the log-roll method, explaining to the patient why this type of turning was necessary. The same nurse who initiated this line of care also went through another patient's medication list after the patient complained of feeling dizzy. She also took the patient's BP thinking that an alteration to BP medication may have been a cause. She did not dismiss the patient claim of being dizzy but took an active role in trying to look for a cause as to its origin. These incidents indicated to me that one aspect of true caring is a willingness to use one's knowledge to do the right thing by the patient.

· During my first week on the ward a couple of the days were extremely hot and one of the patients was sweating and complained about the heat. The nurse I worked with offered to show the patient and then find a fan as there was not one in the room. Although the patient was quite large and had already been showered, the nurse was obviously willing to go beyond what was expected to make the patient comfortable.

In all honesty my first week as a post graduate flew and most of the time I was conscious more of my own behaviour as I was extremely anxious about making mistakes. However the nurse I worked with displayed caring on many occasions most of which involved actively listening to patients' concerns and following up these concerns if necessary.

RN 15-R2

Dear Lorna,

The following are incidents of caring noted during my second week as a post graduate.

· One of the nurses on my shift used her spare time to take one of the elderly medical patients on a walk around the ward which this patient obviously enjoyed.

· A nurse on finding out that a patient enjoyed classical music found a classical music tape in the ward's collection of tapes and set up a tape recorder and played music in the patient's room.

· A nurse took the time to apply make-up to a patient who like wearing it but was unable to apply it due to suffering a stroke. The family later commented on how

nice their mother looked. The nurse not only made the patient feel more comfortable but by taking the time to make the patient look nice she was also helping to reassure the family that their mother was being cared for in a ‘caring’ manner.

‘Caring’ was obvious during some of the patient’s reports in that a few nurses obviously took an active interest in their patient as they were able to discuss their home environment and discuss both the patient’s and the relative’s concerns.

RN 15-R3

Dear Lorna,

I have completed the third week of my post graduate position. The ward however has been very quiet during the Easter period. During my last shift there were only five patients in the ward. Therefore the number of caring incidences noted and listed below is minimal.

· A nurse noted that an elderly patient who was reading the paper had dirty glasses so offered to clean them for the patient. The patient noted the difference after the lenses were cleaned and appreciated the nurse’s action.

· One of the nurses noted a patient had a reddened area on their coccyx and applied a cutinova dressing on the area to help avoid future discomfort for the patient.

· A patient in the palliative care stage of their illness had visitors who were spending many hours at the hospital. As many of the beds were unoccupied at the time, the charge nurse offered some of these beds to the family members if they felt they needed to rest. This same nurse was also concerned about giving the patient too much morphine as the patient had previously stated her wish to see, for the first time, her great grand-daughter who was arriving at the hospital later that night. The nurse was worried that the morphine may make her too drowsy to fulfil that wish. Both these examples of caring show a nurse’s genuine concern for both the patient and family members.

· I personally have noted a caring attitude directed at myself by many of the nurses I have worked with. Although I have make mistakes during the last three weeks no one has make me feel inadequate or stupid although I have felt both on many occasions. Being accepted faults and all by others, thus being accepted as an individual is to me an important aspect of caring.